



***AN INTERPERSONAL COMMUNICATION AND
COUNSELING (IPC/C) SKILLS TRAINING
MANUAL FOR HEALTH CARE PROVIDERS***

Trainers' Guide

JULY 2006

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FOREWORD

The David and Lucile Packard Foundation supported Phases I and II of *Ku Saurara!* Between 2000 and 2005. This project was implemented by the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP) in collaboration with African Radio Drama Association (ARDA) and a consortium of youth serving organizations (YSOs) in 12 states in Northern Nigeria. Phase I was geared towards increasing awareness about healthy reproductive behaviors among youths and improving the socio-cultural environment for youth-friendly health services. Phase II emphasized increasing demand for and access to adolescent reproductive health (ARH) services. Both phases used an entertainment-education approach; a radio variety shows (*Ku Saurara! Or Listen Up!*) was created as a vehicle to convey and model RH behaviors and to promote access to services for youths. Phase II of the project also introduced the use of home video as a vehicle for reaching youths i.e. the *Akwai Mafita* home video (*There is a way out*), an entertainment-education drama that provides RH information, promotes early RH decision-making, and links young people to YSO and quality services. Also, during the same phase of the project using Pathfinder International clinic assessment forms, youth friendly clinics were identified in each of the KS states and clinicians from the identified clinics were trained in Inter-Personal Communication and youth-friendly services. The KS local steering committee in the 12 states conducted 12 step-down trainings for service providers on youth-friendly services, using a training manual that was developed during phase I of the project. Knowing the importance of Inter-Personal Communication in linking clients to services rendered by providers, that’s why the phase III of the project is focusing seriously on it.

Thus, to improve the quality of health services being provided, there is the need to improve the interpersonal communication and counseling (IPC/C) skills of the service providers since research based evidence points to the fact that inappropriate IPC/C skills contribute to low utilization of the health services. Such studies reveal that clients consider health providers unfriendly, rude and impatient treating clients with disdain and contempt.

Improving interpersonal communication skills will no doubt contribute to increased demand for services and more confidence in the health providers. Health providers can employ effective IPC/C to collect and disseminate information and more importantly to promote and establish the necessary relationship of trust and confidence required for compliance with the provision of services that seek to address health issues such as safe motherhood (SM), birth spacing (BS), post-abortion care (PAC) and adolescent reproductive health (ARH), the four specific intervention areas for this third phase of *Ku Saurara!*

By undergoing this training, it is expected that health providers will better understand the need to improve client and provider interactions through exercises and skills building including implementing a client-centered approach, customer service, clarifying values and improving interpersonal communication and counseling skills.

Since improving the quality of health care goes beyond the health facility, this curriculum also

discusses strategies to reach out and provide health communication to the community.

And finally, the curriculum finishes with strategies for monitoring post-training, including familiarizing providers with self-assessment techniques and establishing peer review groups for ongoing evaluation and improvements.

ACKNOWLEDGEMENTS

This curriculum was prepared by

Curriculum Review:

JHU/CCP, ECWA, Pathfinder international, Rotary international, IPAS, CEDPA, FMOH, COMPASS Nigeria with the generous support of The David and Lucile Packard Foundation Nigeria

Resources:

CAFS IPC Counseling Module (1997)

Community Health Education Skills Toolkit, JHU/PCS (1997)

Family Planning Counseling: A curriculum prototype, AVSC International (1995)

Family Planning Course Handbook for Interns, JHPIEGO (1995)

Family Planning Pre-Service Curricula for MW-Nurses, JHPIEGO (1996)

Family Planning In-service Course Handbook for GPs, Nurses, MWs, JHPIEGO (1997)

IEC-In-Action Training Module, JHU/CCP and the Family Planning Unit, Tanzania Ministry of Health (1996)

IEC-In-Action Training Module, JHU/CCP and Ministry of Health Turkey (1997)

Interpersonal Communications Counseling Skills for Service Providers Ethiopia JHU/PCS/AED (1997)

Interpersonal Communications and Counseling Skills for Reproductive Health Providers: Ethiopia JHU/PCS/AED (2000)

Interpersonal Communications TOT Workshop, Honduras JHU/PCS/AED (1997)

National Family Planning Guidelines-Volume 1, JHPIEGO (1994)

Mitchell, Gary, *The Trainers Handbook: The AMA Guide to Effective Training*, (1993).

Piotrow, PT, DL Kincaid, JG Rimon II, and W Rinehart, *Health Communication: Lessons from Family Planning and Reproductive Health* (1997).

Tanzania Basic Training Skills Curriculum, November (1993)

Tanzania Comprehensive Clinical Skills Curriculum, February (1996)

Vella, J., *Learning to Listen, Learning to Teach: The Power of Dialogue in Educating Adults*. (1994).

Zambia Module 4 IPC/C Curricula, Zambia Family Planning Services Project (1997)

Federal Ministry of Health. Interpersonal communication and counseling (IPC/C) skills for Reproductive Health Professionals. National Training Manual, February 2004

Nigeria Partnership for Transforming Health Systems (PATHS); An interpersonal communication and counseling (IPC/C) skills training manual for health care providers

Johns Hopkins University Centre for Communication Programs; Client-Provider communication, successful approaches and tools CD-ROM 2005

Statement of Purpose

The intent of this IPC/C Curriculum is to provide a comprehensive training curriculum for use by organizations in Nigeria wishing to conduct IPC/C training. The curriculum is designed in sessions so that various components can be combined to suit individual needs, circumstances, and teaching styles. The goal is to provide a common approach so that all IPC/C training programs compliment rather than contradict each other in tone, content, and quality.

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NOTE TO THE TRAINER

Welcome to the *IPC/C Skills for Reproductive Health Service Providers Workshop* curriculum! We hope you find this learning tool useful and effective in training reproductive health service providers to improve their skills in effective interpersonal communication and counseling. In an effort to make this the best possible training experience, we would like to share with you some of our lessons learned.

1. **Participant-Centered Learning:** This curriculum has been designed following the adult learning principles focusing on active participation in the learning process following the Experiential Learning Cycle. Participants will be doing the skills that they are learning instead of reading about them, hearing about them and observing them. The role of the trainer is to help the learner through the learning process: the transformation of information into useful knowledge.
2. **Goal of the Curriculum:** The curriculum has the goal of providing the trainers with guidelines to carry out training of health service providers following a model-practice format.
3. **Making it Your Own:** As with all training curricula, we have provided as much information as possible. However, it is up to you, the trainer to make it your own. We encourage you to add your own experience, stories, and complimentary content which may enhance the learning for participants. Good curricula are dynamic and should always be reviewed prior to each use so you can adapt it to the specific needs of each set of participants. Also, each session has suggested timings. As you use the curriculum, you may wish to adjust the timings.
4. **Preparation:** In addition to session-specific materials, you will need some very specific materials during this training course. Please be sure you have them with you prior to starting the course:
 - A laptop or other computer for PowerPoint presentations on CD
 - An LCD projector so that the assembled group can see the presentations
 - Sample IEC materials for each participant
 - A manual for each participant
 - You will need Flip Charts and markers for every session
 - Participants should have their manual with them for every session

Be sure to review the curriculum prior to each session to be sure you have all the support materials for the specific sessions.

5. **Social Events:** Social events can be crucial to the success of a training course. They help participants relax, get to know each other on a personal basis and build bonds that last during and after the workshop. We suggest you organize a social gathering (dance, entertainment, etc.) one or two evenings during the workshop if possible.

Please see the following page for the proposed agenda which will then also be discussed with participants during Session 1.

Good luck and enjoy the workshop!

	Day 1	Day 2	Day 3	Day 4	Day 5
8:15-8:30		Review Day 1	Review Day 2	Review Day 3	Review Day 4
8:30-10:30	1. Welcome, Overview and objectives of the Workshop Pretest	5. Intro to IPC/C Continued and ARH technical overview	9. PAC technical overview and IPC/C Skills: Listening	13. Safe Motherhood overview, practice with IEC materials	17. Birth spacing overview and Provide information to the community
10:30-10:45	Break	Break	Break	Break	Break
10:45-12:45	2. Introduction to the Client Centered Approach and Customer service	6. Introduction to GATHER	10. IPC/C Skills: Listening, Questioning and Paraphrasing (cont.)	14. IPC/C and Special Populations	18. Monitoring an Evaluation of IPC/C s self-assessment and review
12:45-1:45	Lunch	Lunch	Lunch	Lunch	Lunch
1:45-3:30	3. Introduction to the steps to Behavior change	7. Values Clarification	11. Effective use of IEC Materials	15. Review and practice: IPC/C skills, especially use of IEC materials	19. Workshop Synth and Evaluation Wrap Up/Closing Ceremony
3:30-3:45	Break	Break	Break	Break	Break
3:45-5:15	4. Introduction to IPC/C	8. IPC/C Skills: Observation and Establishing Rapport	12. Putting it All Together: IPC/C Skills and GATHER	16. Reaching out to the Community	Facilitators debriefin
5:15-5:30	Wrap Up/Evaluation	Wrap Up/Evaluation	Wrap Up/Evaluation	Wrap Up/Evaluation	
		Facilitators debriefing	Facilitators debriefing		

Evening	Facilitators debriefing			Facilitators debriefing	
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Dear Workshop Participants,

The Johns Hopkins University Center for Communication Programs (JHU/CCP) with funding from The David and Lucile Packard Foundation welcomes you to the *IPC/C Skills for Reproductive Health Service Providers workshop*, in Nigeria.

This workshop's design is based on several well tested sources which have been implemented and evaluated in various training situations worldwide. The Interpersonal Communication and Counseling Skills for Reproductive Health Providers curriculum will enhance skills in interpersonal communication and counseling and IEC materials utilization.

Special thanks are due to the David and Lucile Packard Foundation, ECWA, Pathfinder International, COMPASS Nigeria, Rotary International, IPAS, CEDPA and the Ku Saurara staff in Nigeria as well as Baltimore for the hard work and effort they have put forth in preparing this workshop. We also wish to thank service providers for their continued support.

In this workshop we not only plan to share, but also to learn by listening to the experiences of the participants who are providing reproductive health services. We anticipate the building of professional networks among all of us in the spirit of teamwork for future collaboration in the field.

We wish you a productive workshop.

ACRONYMS

ARH	Adolescent Reproductive Health
BCC	Behavior Change Communication
BS	Birth Spacing
CCA	Client Centered Approach
CCP	Centre for Communication Programs
CEDPA	Centre for Development and Population Activities
CHEWs	Community Health Extension Workers
COMPASS	Community Participation for Action in Social Sector
CS	Customer Service
ECWA	Evangelical Church of West Africa
FC	Flip Chart
FMOH	Federal Ministry of Health
IEC	Information, Education, and Communication
IPC/C	Interpersonal Communication and Counseling
JHU	Johns Hopkins University
KS III	<i>Ku Saurara!</i> Phase III
LGAs	Local Government Areas
MDGs	Millennium Development Goals
MOH	Ministry Of Health
NCA	National Communication Adviser
NGO	Non-Governmental Organization
PAC	Post-Abortion Care
PTA	Principal Technical Advisor
SHCG	State Health Communication Group
SM	Safe Motherhood
SRH	Sexual and Reproductive Health
TOT	Training of Trainers
VIPP	Visualization in Participatory Programs

INTRODUCTION

This curriculum is designed for training in Interpersonal Communication and Counseling (IPC/C) skills for both facility and community based health care providers.

It is an interactive training course that will give service providers skills and hands-on practice in interpersonal communication, counseling, and using IEC materials.

Who is it for?

The IPC/C curriculum is designed for the training of health care providers who are in contact with clients at the facility and community levels. These providers need to acquire good interpersonal skills for their day to day interaction with clients for whom they should provide quality services.

Why should we focus on IPC/C?

- To increase the quality of the service providers' counseling skills.
- To encourage the active and frequent use of information, education and communication (IEC) materials to provide accurate and up to date information during client-provider interactions.
- To assist clients in making informed decisions for themselves and their children.
- To attract new clients and generate increased demand for services. Health facilities like many businesses rely on word of mouth to bring in new customers or clients and therefore benefit from the positive feedback that satisfied customers and clients give to their friends and family.
- To retain clients who need to return for follow up or other services. This is especially important for those with RH problems, ARH issues, SM, BS and PAC.
- To reduce per-customer or per-client costs. When providers and staff communicate well with clients, treat them well and provide the high quality services they want, there is rarely a need to redo procedures to please clients.
- To build a good public image and reputation by word of mouth.

What is the core content of this training?

- Key messages in safe motherhood, birth spacing, post-abortion care and adolescent reproductive health.
- Review of the Micro-Skills of communication including observation, listening, and questioning skills.
- Proficiency in following the GATHER model for effective interactions between providers and clients.
- Consistent and correct use of IEC materials to support the communication and counseling efforts.

Good communication skills are the heart of effective health care. **Providers can have the best technical skills in the world, but if their communication skills are poor, their work will not be effective.** Often, the clients will leave feeling they did not receive quality care and may not return. To be effective and trusted, service providers must be able to communicate with their clients.

“Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”. (Institute of Medicine 2001)

This training material uses experiential learning to teach counseling, communication, education and motivation skills to service providers.

GOAL OF THE WORKSHOP

- Enhance interpersonal communication and counseling skills of health service providers in order to provide quality care services to clients.

OBJECTIVES OF THE WORKSHOP

By the end of the workshop, participants will have:

- Identified IPC/C techniques needed to enhance quality of care during interactions with clients.
- Analyzed barriers to IPC/C and factors that promote effective client-provider interactions for increased service demand.
- Reviewed IPC/C skills needed during encounters with clients.
- Practiced IPC/C skills needed during encounters with clients.
- Practiced providing information to clients in order for clients to make informed health behavior decisions.
- Used IEC materials to give accurate information.
- Discussed strategies for working with special groups.

TRAINING DESIGN

Instructions for Trainers

This curriculum is designed for use in the training of health providers to make interactions with clients at the health facility and communities more effective. This training is intended to actively involve the participants in the learning process by utilizing a variety of interactive training approaches such as role playing, brainstorming, group discussion, observation and demonstration. It is expected that the beneficiaries should have gone through basic clinical training in the key areas of intervention namely; safe motherhood, birth spacing, post-abortion care and adolescent reproductive health.

TRAINING DURATION

This curriculum is designed for use as a guide for a 5-day IPC/C training.

Day 1 - SESSION 1

TOPIC: *Welcome and Overview of the Workshop*

TIME: Two hours

OBJECTIVES: By the end of this session participants will have:

1. Reviewed the objectives of the workshop
2. Introduced themselves to each other
3. Reconciled their own expectations with the workshop objectives
4. Established ground rules for the workshop
5. Completed the workshop skills assessment

OVERVIEW: This session will help facilitators and participants get acquainted, know each other by name, their work site and personal hobbies and activities. It will also help the participants understand the background and rationale of the IPC/C workshop as well as reconcile their own expectations with the objectives of the workshop. Participants will also be familiar with training methods to be used, logistic arrangements and the schedule for the course.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
Opening speeches and welcome	30 min	Individual welcome remarks by supporters and organizers	
Introduction exercise	30 min	Group exercise	Power Point
Workshop goals & objectives. Workshop logistics	30 min	Group discussion	Power Point: Welcome, flip chart,
Pre-Test	30 min	Individual exercise	Handout

1. OPENING SPEECHES AND WELCOME

Opening speeches may be made from the supporters, guests and organizers of the Ku Saurara IPC/C reproductive health service providers' workshop. The objective is to let participants know why they are here, and the role they will play after this workshop as well as making them feel welcome and relaxed.

NOTE: If there are no guests, the lead trainer should make a few remarks to welcome participants before continuing with the introduction exercise.

2. INTRODUCTION EXERCISE

There are many different introductory exercises you may want to use. The objective is to do something fun to begin learning each other's names, hobbies, interests, positions, work site and expectations for the workshop. Here is a suggestion: The Symbols Exercise.

Symbols Exercise

Allow all participants five minutes to find an object in the training room that symbolizes them in some way, encourage them to be creative.

For this icebreaker, try to get participants to think creatively regarding their work they do and the skills that they are required to use on a daily basis. For example, the trainer may say that a cup of coffee might symbolize that a person needs a lot of energy, or "caffeine" in his/her work.

If participants can not find an object in the room, they can find an object from outside but have them just mention it, like leaves from a tree or water etc. or they can draw it.

Once all the participants have selected their symbol, have everyone (participants, facilitators, guests, etc.) form pairs. Show **PowerPoint slide** with the interview questions. Ask each pair to interview each other and find the answers to the questions. Of course, they should not be limited to only these questions. They should try to learn as much as they can about each other.

After 10 minutes (or when everyone is finished), ask each pair to stand and introduce each other and explain the symbols they chose to represent themselves. Continue around the room until everyone has been introduced.

Briefly summarize some of the similarities in the symbols that emerged.

Application

Getting to know you!!

To learn more about each other, interview your partner and find out the answers to the following questions.

1. Name, title, and organization or place of work.

2. Something unique or humorous about the person.

(Example: My partner speaks five languages.)

(Example: My partner snores, but only in soprano.)

3. Explain the symbol selected that represents the person's work.

(Example: cup of coffee – needs a lot of energy)

Feel free to find out more interesting information and share that too!

3. WORKSHOP GOAL, OBJECTIVES AND AGENDA

This is the kick-off session and sets the overall tone of the workshop. The overall tone should be relaxed, supportive, fun, practical and inspirational.

Participant's expectations and concerns

Provide participants with flashcards of two different colors (or plain sheets of paper if cards are not available). Ask them to write their expectations from the workshop on one and their concerns on the other. When they are finished, collect the cards or papers back. Arrange the cards on the wall or flip chart and go over them as a group.

Then, Facilitator presents the **slides**: goal of the workshop and workshop objectives. Ask participants if other objectives need to be added to address their expectations or concerns.

GOAL OF THE WORKSHOP

- Enhance interpersonal communication and counseling skills of health service providers in order to provide quality care services to clients.

OBJECTIVES OF THE WORKSHOP

By the end of the workshop, participants will have:

- Identified IPC/C techniques needed to enhance quality of care during interactions with clients.
- Analyzed barriers to IPC/C and factors that promote effective client-provider interactions for increased service demand.
- Reviewed IPC/C skills needed during encounters with clients.
- Practiced IPC/C skills needed during encounters with clients.
- Practiced providing information to clients in order for clients to make informed health behavior decisions.

- Used IEC materials to give accurate information.
- Discussed strategies for working with special groups.

AGENDA

Show **slide**. Review the agenda for the workshop. Insert changes suggested, if any.

Ground rules

In order to maximize available time, it is usually helpful to set rules that are binding on all members to guide their behavior and hence make proceedings smooth. The facilitator invites suggestions from the group. Approved suggestions are listed on the flip chart and an acceptable time agreed to by all is listed. A chief whip will be appointed to enforce the rules and fine offenders. For example, a fine may be to sing or facilitate the energizing session.

TRAINER'S NOTES

- **What is an IPC/C workshop?**
 - It's a curriculum for a five-day training course in Interpersonal Communication and Counseling skills development. It is an interactive training course that will give reproductive health care providers vital skills and hands-on practice in:
 - ❖ key interpersonal communication skills
 - ❖ effective guidelines for client-provider interaction
 - ❖ practice using IEC materials
 - ❖ information on working with special populations
 - ❖ empowering clients to make informed decisions on sexual and reproductive health
- **Who is it for?**
 - ❖ Reproductive health service providers who are in contact with clients.
- **Why should we train on Interpersonal Communication and Counseling?**
 - ❖ To increase the quality of service providers counseling performance.
 - ❖ To encourage the active and frequent use of IEC materials to provide information during client-provider interaction.
 - ❖ To assist clients in making SRH informed decisions.

Research has shown that clients who have a good relationship with their health provider tend to be more satisfied with their care and to have better results. To improve and increase utilization of integrated services at the health facilities, community members need to value and appreciate the services they receive. When providers feel that their efforts are appreciated, they are more likely to have more positive attitudes and this will lead to improved performance.

- **What is this curriculum based on?**
 - ❖ An integrated reproductive health focus.

- ❖ The foundation laid by basic and comprehensive curricula, developed and trained by national Reproductive Health program trainers.
- ❖ Proficiency in following the GATHER model for effective counseling.
- ❖ Review of the foundation communication skills, called Micro-Skills.
- ❖ Consistent and correct use of IEC materials to support the counseling effort.

Good communication skills are the heart of effective health care. A provider can have the best technical skills in the world, but if his or her communication skills are poor or lacking, his or her effectiveness with clients will be minimal and the clients will probably perceive the quality of care they receive from that provider as being of "poor" quality.

This course uses *experiential learning* to teach counseling, communication, education and motivation skills to participants. Research has shown that people remember 20% of what they hear, 40% of what they hear *and* see, and 80% of what they **discover for themselves**¹. For this reason, participants in this course increase IPC/C skills not through listening to lectures, but by practicing the techniques. The exercises presented here encourage participants to discover the techniques for themselves and learn how to apply them to their daily lives. Participants will come to the course with a wealth of personal experience in interpersonal relations. For this reason, the course doesn't try to give them all the answers; rather, they are encouraged to provide the answers themselves.

4. LOGISTICAL INFORMATION

Explain any logistics arrangements that have been made regarding accommodation, transportation, meals (especially the lunch and the two breaks), social events, other after hour events planned, etc.

5. QUESTIONNAIRE

Pre-Test: 30 min.

Hand out the **Workshop Questionnaire** and ask participants to answer the questions individually. Explain that it is an assessment of what they know now and assists to determine the learning that takes place. It will also be useful to know which areas need to be focused on. Collect all questionnaires when they have been filled out.

¹Vella, J: *Learning to Listen, Learning to Teach: The Power of Dialogue in Educating Adults*. San Francisco: Jossey-Bass, 1994.

Workshop Questionnaire
INTERPERSONAL COMMUNICATION/COUNSELING SKILLS
FOR REPRODUCTIVE HEALTH PROVIDERS QUESTIONNAIRE

Number _____

The answers to the following questions will help us tailor the contents of the workshop sessions to the needs of the participants. There are no wrong answers to the questions. We greatly appreciate your responses.

1. When do we use interpersonal communication skills?

2. Name some different types of communication?

3. What are the factors that may influence behavior change?

4. What are some of the stages one may follow when changing our behavior?

5. Give 3 examples of good listening skills during interpersonal interactions with a client.

6. When do counselors use open-ended questions with clients?

7. Describe the steps that are part of the GATHER process.

8. Name some advantages for the provider in using information, education and communication materials during counseling.

9. Name some sources of rumors and misinformation about reproductive health.

10. Give two examples of non verbal communication.

11. Please explain the meaning of “establishing rapport” with a client during counseling.

12. What are some of the client’s rights during health counseling?

True or False:

1. Counselors should be aware of their own values and attitudes, only when counseling special populations. _____
2. During counseling, the client follows the decision made by the provider because he or she has understood the client’s needs. _____
3. Everyone follows the same steps when changing his or her behavior. _____
4. Communication is a process that seeks to reduce uncertainty. _____

INTERPERSONAL COMMUNICATIONS / COUNSELING SKILLS FOR REPRODUCTIVE HEALTH PROVIDERS

ANSWER KEY

Symbol_____

The answers to the following questions will help us tailor the contents of the workshop sessions to the needs of the participants. There are no wrong answers to the questions. We greatly appreciate your responses.

1. When do we use interpersonal communication skills?
We use interpersonal communication in almost all aspects of our life, during work and with our family, neighbors, and children.
2. Name some different types of communication.
Intrapersonal, Interpersonal, Mass Media, Organizational
3. What are the factors that may influence behavior change?
Physical, Rational, Emotional, Skills, Family and Personal Social Structures
4. What are the steps that one may follow when changing our behavior?
*Pre-knowledge
Knowledge
Approval
Intention
Practice
Advocacy*
5. Give 3 examples of the listening skills that health providers need to practice during interpersonal communication encounters with clients.
*Observation Verbal and non verbal
Establish rapport
Listen attentively
Use open ended questions
Reflect feelings
Paraphrase
Use IEC materials to explain information*
6. When do counselors use open ended questions with clients?
When they need to find out more information about the client.
7. Describe the six steps of the **GATHER** process.
GREET
ASK

TELL
HELP
EXPLAIN
RETURN VISIT

8. Name some advantages for providers in using Information education and communication materials during counseling.

IEC Materials:

- *Help the client understand information given by the provider*
- *Save provider time.*
- *Maintain client's attention for a longer time*
- *Can be given to the client to take home and discuss with partner*

9. Name some sources of rumors and misinformation about reproductive health?

- Poorly trained service staff
- Television and radio
- Friends and family
- Newspapers

10. Give two examples of non verbal communication.

A smile, eye contact, body language, facial expressions

11. Please explain the meaning of “establishing rapport” with a client during counseling.

Implies building trust, liking one another, having each other's best interests in mind, building a relationship that is harmonious or empathetic.

12. What are some of the client's rights during health counseling?

Information
Safety
Dignity
Opinion

Access
Privacy
Comfort

Choice
Confidentiality
Continuity

True or False:

1. Counselors should be aware of their own values and attitudes only when counseling special populations. **FALSE**
2. During counseling, the client follows the decision made by the provider because he or she has understood the client's needs. **FALSE**
3. Everyone follows the same steps when changing his or her behavior. **FALSE**
4. Communication is a process that seeks to reduce uncertainty. **TRUE**

Day 1 - SESSION 2

TOPIC: *Introduction to the Client Centered Approach (CCA) and Customer Service*

TIME: Two hours

OVERALL GOAL: Gain an appreciation for the importance of a client centered approach and how it contributes to increasing demand for integrated services and utilization of facilities.

OBJECTIVES: By the end of this session, participants will have:

1. Explained the meaning of Client Centered Approach
2. Identified at least 6 reasons for improving Client Centered Approach
3. Discussed the effect of not having a Client Centered Approach
4. Described the elements of Client Centered Approach
5. Identified at least 6 rights of clients
6. Discussed ways of implementing client’s rights at the facilities and community levels

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction	10 min.	Brainstorm	Power Point, Flip Chart, Markers
2. What is meant by a Client-Centered Approach?	30 min.	Discussion	Power point, Flip Chart, VIPP cards, Markers
3. Client-centered vs. Provider-Centered	30 min	Discussion and exercises	Power point, Flip Chart, VIPP cards, Markers
4. The Rights of the Client	20 min	Group discussion	
5. Customer Service	20 min	Brainstorm/Group discussion	Power Point, Flip Chart, Markers

6. Conclusion	10 min	Group discussion	
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1. INTRODUCTION

This session will introduce participants to the importance of a client-centered approach. It will also help them recognize and understand the difference between a client-centered and a provider-centered approach.

Tell participants that you want them to do a mental exercise to get them thinking about what Client-Centered means:

- Ask participants how would they like to be treated when they go to banks, petrol station, super-markets etc?
- What happens when the providers do not meet your expectations?
- Acknowledge relevant responses and introduce the topic as the heart beat of any service delivery system.
- Ask 2 or 3 participants to share their experience on how they were treated when they went for service somewhere e.g. Bank, Hospital etc.
- List their responses on Flip chart and underline the positive ones.
- Ask them what their reactions were when the interactions were positive or negative?
- Acknowledge their responses and say **“Do unto others what you want others to do unto you”**.

Based on their personal experiences, start with a brainstorming exercise for the group to define “Client-Centered Approach”.

Brainstorming

- Ask participants to explain what is meant by Client Centered Approach
- Record responses on the flip chart, this can also be done with VIPP cards.
- Display **slide** with the definition of Client Centered Approach and compare with participants’ responses
- Discuss points that were missed or underline key points in the trainers definition

2. BASIC ELEMENTS OF A CLIENT-CENTERED APPROACH

Large Group Discussion

- Ask trainees what they think makes clients satisfied with the care they receive
- Record responses on flip chart.

Point out that health facilities are taking steps to improve quality of services such as renovating or upgrading health facilities, adhering to clinical protocols, ensuring regular drug and commodities supply and taking infection control measures. Despite these efforts, clients are still unsatisfied with the care they receive. Providers are taken to be unfriendly, harsh, rude and impatient. Clients feel they receive poor quality of services and do not return and spread the word around.

- Ask providers to give reasons for improving Client Centered Approach
- Record and acknowledge responses.
- Present **slide** with the reasons for improving Client Centered Approach (listed in Trainer's Notes below) and briefly discuss each point
- Ask trainees what could be the effect of poor Client Centered Approach
- Present **slide** with the results of poor CCA (also listed in Trainer's Notes) and reconcile both lists
- Clarify missed points

TRAINER'S NOTES

Client centered approach to service delivery means having the client as the main focus of service delivery with the aim to meet and where possible surpass the expectations of the client. It is an approach that meets the rights of the clients to access, information, choice, confidentiality and safety.

Although we would like to think that every health system, health worker and other service providers, has the client in focus, this is not normally so for various reasons.

For the purpose of this training we will be primarily concerned with looking at meeting the client's needs from consumer satisfaction information and not clinical performance. For instance, do the service providers communicate well and do clients get the health services needed?

As integrated health providers, we seek to provide services that meet the expectations and needs of the clients and community. Experience has shown that clients feel comfortable and are even willing to pay for the service when they feel it is of good quality and when they meet their expectations.

Meeting established targets, such as no out of stock syndrome, adhering to clinical protocols was often considered indicative of offering quality services. Despite these factors, people are still

unhappy with the services offered and do not utilize them fully. Therefore, it is very important to place the clients' perspective at the forefront thus ensuring that clients' expectations are met satisfactorily. Studies have shown that an important factor that affects the quality of client provider relationship is the client's perception of the services they receive.

Elements of Client Centered Approach

- Information given to clients
- Technical competence of the provider
- Interpersonal relations
- Mechanism to encourage continuity and follow up
- Access to services
- Efficiency
- Effectiveness
- Positive health facility environment

Reasons to improve the Client Centered Approach

- Increase the number of clients who use integrated services
- Improve the reputation of staff at facility and community levels
- Satisfy the needs and expectations of clients
- Reduce the number of clients who discontinue services
- Satisfy a new need
- Satisfy an old need at a new level.
- Produce results within budget limitations
- Provide consistent and uniform information
- Meet desired and needed results that was not being achieved through former approaches
- For the health service system to respond to societal needs
- Increase and sustain the viability of centers

Results of not having a Client Centered Approach

- Wastage of resources such as human, equipment, time and supplies
- Decreased job satisfaction and motivation for providers
- Decreased safety for clients and providers
- Decreased satisfaction of clients
- Increased drop out rates and loss of clients resulting in increased defaulter rates
- Fewer new clients
- Poor image of the health facility and providers
- Poor compliance with prescribed treatments

Factors that facilitates Client Centered Approach

- Good IPC/C Skills
- Availability of IEC materials

- Technical competence of the provider in the use of IEC materials
- Provision of privacy and confidentiality for the client
- Availability of enough time for client-provider interaction

Barriers to CCA

Some of these include;

- Provider's lack of IPC & C skills
- Lack of job aids
- Lack of technical competency on the use of job aids
- Lack of privacy and confidentiality for the client
- Work overload for the provider

Client vs. Provider Focused

While providers are more concerned with ensuring technical accuracy, the clients are more concerned with issues such as being treated with respect, etc. Though we are more concerned with the clients' perspective, it is important to note that both sides are needed to meet up with quality services.

For the provider, adhering to clinical protocols and standards for service delivery, organization, policies and management are paramount. This could lead to efficient and effective work environment, positive treatment outcomes for clients and provider.

While for the client it could include client expectations, how client felt he or she was treated, feeling of satisfaction with the treatment. This could lead to positive client behaviours (treatment compliance, reduced drop out rate, continuation with treatment), client satisfaction, good image of health services and providers.

3. CLIENT-CENTERED Vs. PROVIDER-CENTERED SERVICES

Large Group Discussion

Present **slide** with the eight elements of CCA explaining that this is a way to think about and evaluate quality health services.

- Give eight trainees each a card with one element of CCA written on it. Then ask the trainees to arrange the card with the one card that represents the element that most affects all the other elements in the center. Ask them to provide the rationale for their decisions.
- Ask the other trainees whether they agree or disagree and why.

- Point out that the clients will not be satisfied with services if client and provider interactions are not good.
- Discuss that clients and providers often view quality differently.
- Providers often view quality in terms of technical and organizational aspects (provider focused) while the clients view quality in terms of interpersonal relations/client provider interactions (client focused).

Small Group Work

Divide Participants into 2 groups.

- On a flip chart, ask participants to generate what constitutes good interaction from the provider and client's perspective.
- Ask participants to present their group work
- Display and discuss **slide** with **provider Vs client focus**.
- Explain why all the eight elements of CCA must be addressed if quality service is to be rendered.

Role play

A 20 year old girl who is sexually active comes to your clinic for contraception after terminating an unwanted pregnancy. Act using Provider centered approach, or CCA.

- Review with trainees what client centered service providers are expected to do.

Small Group Work

- Keep the participants in their 2 groups of providers.
- Ask participants to create a list of barriers to focusing on the client in their health facilities and the communities.

Large Group Discussion

Allow groups to present their work. Solicit feedback from other participants

- Ask for clarifications where necessary and emphasize barriers to interpersonal relations and mechanisms to encourage continuity and follow up.
- Discuss possible solutions in plenary
- Present **slide** on barriers and solutions
- Add any missing information

- Allow questions, discuss and clarify
- Display **slide** with provider and client centered attitudes
- Review each point and provide clarifications where required

Organization/service provider centered attitudes	Client centered attitudes
It is considered a privilege for clients to come to the clinic and have trained service providers take care of them.	Service providers appreciate the opportunity to provide services to their clients.
Service providers know what is best for a client.	Service providers spend time helping the client choose the most appropriate options to meet their needs. Decision-making is a collaborative process between the provider and the client.
Service providers are concerned primarily with efficiency and technical competence.	Service providers understand that though technical competence and efficiency are important, service must be delivered in a clinic that is hospitable, responsive, polite, respectful, and friendly to clients.
Attending to each individual client’s needs is too time consuming because it increases the time it takes to provide services.	Taking time to listen and meet the client’s individual needs saves time, reduces unnecessary return visits, and encourages the client to continue to come to the clinic for services next time.

Large Group Exercise

- Tell participants that this is their opportunity to undertake an honest self appraisal.
- Display FLIP CHART with question “which type of service provider were you before this training”?
- Ask them to keep in mind the points you have covered as a group.
- Explain that everyone will have ample opportunity to improve, and to give themselves credit for the things they are already doing well – now is their chance to build on them!

4. THE RIGHTS OF THE CLIENT

- Display **slide** with the rights of a client

TRAINER'S NOTES

You are about to discuss a rather radical idea: clients have rights in the counseling situation. Present the Rights of the Client; they were developed in several countries with the assistance of the United Nations. These rights are based on the premise that for clients to make informed choices, they must feel empowered. In traditional medical situations, clients felt they were told what to do and did not have the right to question what they were told. However, research evidence was showing that clients who exercised the rights listed below were more likely to change their behavior and sustain that change. The Rights of Clients support the fact that interpersonal communication is two-way.

Large Group Discussion

Ask a participant to read one right at a time. It goes against the traditional medical model which is why it is considered radical. However, it supports informed choice, a very key issue in family planning.

Ask trainees what they understand the rights of the client to mean use the trainer's notes above to help you guide discussion.

- Ask participants to say, in their own words, the link between these rights and Client Centered Approach
- Ask if they've seen the clients' rights before; then have them do a quick exercise.
 - ❖ Break into groups of 2 or 3 – one group for each right;
 - ❖ identify barriers THEY see in relation to these rights;
 - ❖ discuss possible solutions to overcome these; and
 - ❖ then share back quickly. The key is to get them to focus on how these rights are relevant in their daily work.
- Ask other participants if they have other suggestions for ways in which the rights of the clients can be implemented at the health facility and community

|

Rights of the Client: Every client has the right to:

Information:

To receive clear information to learn about the availability, benefits, side effects or possible problems associated with health care services and treatment.

Access:

To obtain services regardless of age, sex, color, tribe, marital status, location or socio economic class.

Choice:

To decide freely whether to use health services and what to use that best meets their needs, goals and life styles.

Safety:

To receive effective services, treatments and care without harm.

Privacy:

To have a private environment during counseling and service delivery.

Confidentiality:

To be assured that any personal information divulged will not be shared in public.

Dignity:

To be treated with courtesy, enthusiasm, attentiveness and respect.

Comfort:

To feel comfortable while receiving services.

Continuity:

To receive appropriate health services, drugs, commodities and supplies for as long as needed.

Opinion:

To express an opinion about the health services being offered without fear and with confidence that the opinion will be considered valuable.

5. Introduction to Customer Service

Brainstorming

- Ask participants what they understand by customer service.
- Record responses on FLIP CHART.
- Display **slide** with meaning of customer service and reconcile with participant's responses.
- Point out definitions from the customer's perspective.
- Summarize by providing in-depth meaning of Customer Service and explain that Health providers can increase demand for their services by learning from the success and principles of customer oriented businesses. As health facilities move forward toward providing high quality clinical services backed by a strong customer service approach, they will become increasingly valued by their clients and communities.

TRAINER'S NOTES

Customer service means providing assistance to clients in a way that increases their satisfaction with your program or facilities. It is based on the continuous concern for client preferences, both in staff interactions with clients and in design of services. It maintains that facility staffs are accountable to clients, that clients have rights, which staff needs to respect.

Customer service is people serving you in a way that meets your needs, makes you feel they care about you and your well-being, and makes you want to recommend their services to your family and friends.

Customer service is simply an organization's ability to supply their customers' wants and needs. Excellent customer service (is) the ability of an organization or individual to constantly and consistently exceed the customer's expectations.

- It is an ability, and a skill that is constantly and consistently practiced - they're doing it **all the time** and have proven this ability.
- "It exceeds the needs" - more customer **delight** than customer **satisfaction**.
- The provider - makes the customer an individual, rather than a group, with his special set of needs and wants.

From a customer's point of view however, good customer service is defined as how she/he perceives that an organization has delighted her/him, by exceeding to meet her/his needs".

Improving customer service involves making a commitment to learning what our customers' needs and wants are, and developing action plans and activities that implement customer friendly processes.

Health services need to be provided with distinction. Try to know your customers and recognize their individual needs. Be convinced that you are offering them valuable service. This is key and crucial to good customer service

When you can show concern about what matters to your customer, you are a step closer to acquiring a customer for life.

It is necessary to be honest with your clients. The health facility staff should be in a position to let the client know the truth about issues especially as it relates to their health. For instance, if you are aware that treatment will no longer be free, do not promise clients they will still continue to receive free treatment just to get them to visit the health facility. If diagnostic equipment is not functioning well, do not pretend, keep them in the dark or let them wait unnecessarily.

By the time the client suspects that you are not being honest, he will feel disappointed and you run the risk of losing the trust secured. Some times, when clients do not receive a particular service consistently they are disappointed and fail to return. In addition, the word gets round and others too (who would otherwise still benefit from the available services) are also discouraged from utilizing the health facility.

6. ADDING CUSTOMER SERVICE TO CLINICAL SERVICES

Large Group Discussion

- Ask trainees reasons for adding Customer Service to clinical services
- Record responses on FLIP CHART

Small Group Discussion

- Divide group into 3 smaller groups
- Display **slide** with reasons
- Ask trainees to prioritize responses and give reasons for choice
- Each group to present first 3 most important reasons

TRAINER' S NOTES

Reasons for adding customer service to your quality clinical services

- Attracts new clients and generates new demand for services. Health facilities like many businesses rely on word of mouth to bring in new customers or clients and therefore benefit from the positive feedback that satisfied customers and clients give to their friends and family.
- Retains clients who need to return for follow up or other services. This is especially important for those with RH problems, ARH issues, SM, BS and PAC.
- Reduces per-customer or per-client costs. When providers and staff communicate well with clients, treat them well and provide the high quality services they want, there is rarely a need to redo procedures to please clients.
- Builds a good public image and reputation by word of mouth
- Dispels false rumors about methods and services
- Raises staff morale and performance by working together to fulfill clients' needs and getting positive feedback from clients about the services.

Large Group Discussion

Discuss need to offer valuable service, show concern and be honest with clients to sustain trust

- Summarize by presenting **slide** on commitment to Customer Service and discuss the positive attitudes, **relate with the client-centered approach (CCA) discussed under the previous topic.**

7. INITIATING A CUSTOMER SERVICE APPROACH

Large Group Discussion

- Display **slide** on initiating Customer Service approach
- Ask trainees to take points one by one and provide explanations
- Encourage trainees to cite personal real life examples as they apply to each health facility and community

TRAINER' S NOTES

Initiating the customer service approach

An Interpersonal Communication and Counseling (IPC/C) Skills Training Manual For Health Care Providers

Developing a customer service focus is an important and challenging task that requires the participation and commitment of all staff: this includes receptionists, health staff, accounts clerks and gatekeepers. They all need to understand that they have an important role in making each client's visit efficient and pleasant and that they must participate. It is essential to incorporate customer service attitudes and skills in all their interactions with clients.

- Introduce staff to the customer service concept. Hold a seminar or meeting on CS.
- Review the anticipated benefits of customer service in terms of both the clinic and the community it serves.
- Encourage staff to think about their own experiences as clients in health facilities and customers of local businesses so that they can identify good and bad examples of customer service and determine how those experiences have affected where they decide to go for services.
- Take the lead in modeling desired customer service behavior. For example speaking with clients who are waiting to be seen or have just received services to better understand what they need or think of the services. Modeling customer service helps show other staff the kind of respect, friendliness, consideration and attentiveness that you want them also to extend to clients.
- Providers and staff should identify some relatively easy but important guidelines for interactions with all clients that staff will follow. For example, clients will be addressed in a respectful and culturally appropriate manner such as Miss, Mrs. or Mr. instead of 'grandmother', 'the abortion case', or the 'STI case'.
- Providers and staff are encouraged to contribute their suggestions to improving customer service at regular staff meetings. Feedback from clients should be shared at these meetings as well.
- All staff should receive feedback on their performance in modeling customer service. This is not a punitive process but staff should be recognized for their efforts and encouraged to always look for ways to improve.

5. CONCLUSION

Application

- Ask participants what they feel about the Client Centered Approach, rights of the client and customer service.
- What factors could make this application difficult in your work situation?
- Ask participants to brainstorm their own solutions and record them on a flip chart.
- Ask participants in what situation they can use acquired knowledge.
- Ask for clarifications to ensure applications relate to learning's.

Evaluation

Ask participants to mention at least 5 elements of the Client Centered Approach

- What are the effects of not having a Client Centered Approach?
- Why are client's rights important to Client Centered Approach?

Summary

- Review session objectives checking to what extent these have been met.
- Establish link to the next session.



Day 1 - SESSION 3

TOPIC: *Introduction to the Steps to Behavior Change*

TIME: Two hours

OVERALL GOAL: Gain an appreciation for the complexity of communication and understand that effective trainers are effective communicators.

OBJECTIVES: By the end of this session, participants will have:

1. Identified steps to behavior change
2. Reviewed basic elements of communication
3. Described the different types of communication
4. Described barriers to communication and how to overcome them
5. Described how Interpersonal Communication fits into the steps to behavior change

OVERVIEW: This session will help participants see the connection between effective communication and effective training. It is a combination of presenting new ideas which lay the foundation of communication and exercises which illustrate the concepts.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction	10 min.	VIPP	VIPP cards (or 2 half-sheets of blank paper per person)
2. Steps to Behavior Change	40 min.	Discussion	
3. Basic Elements of Communication	20 min	Discussion and exercises	
4. Types of Communication	20 min	Group discussion	

5. Barriers to communication	20 min	Group discussion	
6. Conclusion	10 min	Group discussion	

1. INTRODUCTION

This session will provide the foundation for the workshop. It is where we discuss what communication is and how interpersonal communication fits into behavior change.

Communication is everywhere and pervasive in all aspects of our lives. Thus, we can not take communication for granted. To be effective communicators we must understand the nature of communication. Review the objectives of the session with participants.

EXERCISE: Begin this section by asking participants to think of a recent behavior change they did personally (stopped taking cola nut, changed diet, began exercising, started jogging, etc.). Ask them to write down on one of their two VIPP/Cardboard paper cards the behavior that they changed and how long it took for them to successfully change that behavior. On the other card, ask them to write down what motivated them to change their behavior.

Ask a few volunteers if they are willing to share their experience. This exercise illustrates personally how difficult it is to make a behavior change and also to sustain that change. It requires individual motivation and social support.

2. STEPS TO BEHAVIOR CHANGE MODEL

Use the Power Point **slides** and lead a discussion on the steps to behavior change based on the trainer’s notes. Emphasize that behavior change really is a process.

We cannot talk about communication for health without talking about behavior change. Behavior change is a slow process by which individuals’ progress through several stages. These stages, however, do not necessarily follow a linear process that all individuals must go through when changing their behavior. Some individuals may experience all five stages but not necessarily in the same order. At times, people change their behavior because of social pressure or the desire to conform to social norms, not because they have personally been convinced that it is the right thing to do. After a period of practicing the new behavior, they may become persuaded of its advantages. This encourages them to approve of the new behavior and continue practicing it.

Pre-knowledge: One may have heard about a new behavior but does not have adequate information about the behavior.

Let’s use making a safe birth plan as an example. A woman who has not yet been pregnant may have heard others mention a safe birth plan, but she does not see the relevance to herself, so she has not learned about it.

Knowledge: One first learns about a new behavior.

- *Recalls birth plan messages*
- *Understands what a safe birth plan means*
- *Can recall safe birth planning messages and the danger signs of pregnancy.*

Approval: One then approves of the new behavior

- *Responds favorably to safe birth planning messages*
- *Discusses safe birth planning with personal network (family and friends)*
- *Thinks family, friends and community approve of safe birth planning*
- *Approves of safe birth planning*

Intention: One then believes this behavior is beneficial and intends to adopt it.

- *Recognizes that safe birth planning can meet a personal need*
- *Intends to consult a provider*
- *Intends to practice safe birth planning anytime she is pregnant.*

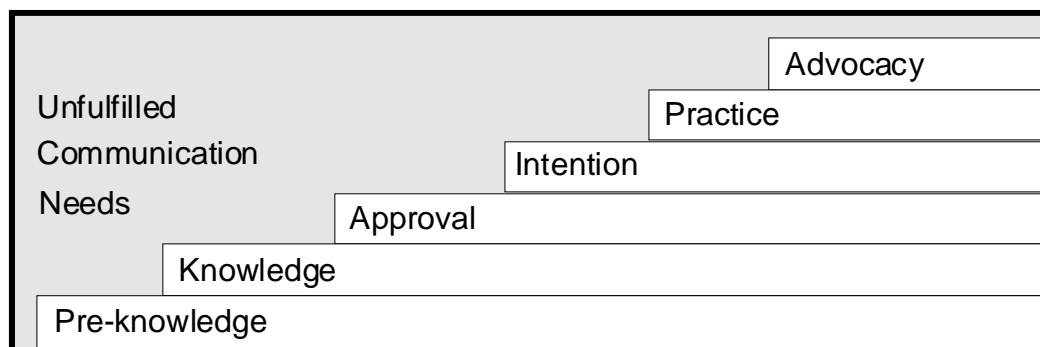
Practice: One then practices the new behavior.

- *Goes to a provider for information/supplies/services*
- *Makes arrangements with family, provider, community members*
- *Always has a safe birth plan for subsequent births.*

Advocacy: One can then promote the new behavior through one's social networks as a satisfied user.

- *Experiences and acknowledges personal benefits of safe birth planning and tells friends and family about it in an effort to get them to use one, too.*

How we frame our messages depends on the stage our intended audience is in within the steps to behavior change.



Effective communicators will identify where their audience is on the steps to behavior change and help them move on to the next step(s).

- Ask trainees to generate ideas about the link between the role of the service provider and getting the client to change behavior. Ask them what they can do to positively impact on the client at different stages.

Factors that influence behavior change

Continue the discussion linking communication with behavior change. As service providers, our goal is to help our clients make decisions and change their behavior. However, we cannot force anyone to change. It is helpful to understand the steps people go through when they do change their behavior. Keep in mind that simply knowing something does not lead to behavior change. (How many doctors smoke, knowing full well the negative consequences it has on health!) There are many more factors and influences that impact behavior change.

Ask participants: What factors motivate people to change the way they think?
 What factors cause people to change behavior?

Tell the participants to think back on the behavior change that they made, and refer to their VIPP answers on what motivated them.

Put these into categories along the following groups – for example, if someone said they quit smoking because their husband asked them to, that would be a family network influence. If someone started to play tennis because they just learned how, that would be a skills influence. Etc. Put the cards in groups to show the participants how many different kinds of motivators there are. Then talk through the groups with them.

Some examples of different factors that influence behavior change:

- **Physical Stimuli** - based on a person's current physical state as well as fear of future pain and discomfort or the memory of past pain.
- **Rational Stimuli**- based on knowledge and reasoning (if people have the facts they may choose to do the right thing).
- **Emotional Stimuli** – based on intensity of feelings of fear, love or hope.
- **Skills** – based on the person's capacity to adopt and continue a new behavior.
- **Family and Personal Networks** – based on the influence from family and peers.
- **Social Structures** – based on the impact of social, economic, legal, and technological factors on the daily life of a person.

3. BASIC ELEMENTS OF COMMUNICATION

Present and discuss the basic elements of communication. It is good to relate this discussion to the service provider-client relationship.

Communication as a Process

- Ask participants why they need to communicate effectively when implementing services
- Record responses on FLIP CHART
- Display **slide** with reasons for effective communication when providing services and reconcile with responses

Ask participants to define communication:

A process of transmitting and receiving information on a particular topic between two or more people who share the same code (verbal and non verbal) aimed at reaching a mutual understanding.

TRAINER'S NOTES

It is important to understand that communication is a process. This implies that communication occurs over time. What happened in the past has a bearing on what is happening now. What is happening now will influence what will happen in the future.

Communication is not a product. It is not simply producing a brochure, a poster or a drama. Effective communication interventions are the result of closely following a road map. It consists of a wide range of behaviors that include listening, reading, writing, talking, and thinking. These behaviors occur over time and often overlap with one another. While we seek mutual understanding when we communicate, research tells us that communication is not finite; it never really ends. Research also says that perfect communication is difficult to achieve.

Use the **slides** to go over the following communication principles:

- The key to effective communication is effective listening.
This is especially important during service provider-client interactions. Not correctly understanding each other will greatly diminish the possibility of effective behavior change.
- Frame your message carefully. People select what they will:
 - ❖ See
 - ❖ Interpret
 - ❖ Remember
 - ❖ Forget
- Actions speak the loudest. When there is a contradiction between verbal and non-verbal, go with the non-verbal. Actions reflect our true feelings, needs and desire best.
- Communication is a social behavior. It occurs in a social context, not in a vacuum. Therefore, effective communicators will always look for the greater social influences on a person's individual behavior.
 - Words do not have meanings; meanings are in
 - ❖ People

- ❖ Contexts
- ❖ Relationships

- People often receive messages from multiple sources. Frequently, these messages contradict each other. We must understand and help clarify these messages for our clients.
- Time and power relationships are critical dimensions of communication.
- Communication is the reduction of uncertainty.

4. TYPES OF COMMUNICATION

Ask participants to describe the different types of communication giving examples – examples will help illustrate the types whether or not the participants can put a name or label to them. Record their answers on a flip chart, then show them **slide** and explain the following.

Current literature recognizes four forms of communication:

- 1) **Intra personal** - communication with oneself. It includes the justification we make for our actions.
- 2) **Interpersonal** - person-to-person communication, verbal and non-verbal exchange that involves sharing information and feelings between individuals or in a small group. It is face to face, and all parties involved are senders and receivers.
- 3) **Mass communication** – transmitting messages to large audiences through the mass media
- 3) **Organizational communication** - communication that happens within a group or organization, or among organizations. Members are aware of each other's existence; they have a common interest and work together for the same goal.

5. BARRIERS TO COMMUNICATION

TRAINER'S NOTES

It is not always that the intended message from the source gets to the audience/receiver as a whole package. Along the line there could be barriers or distortions.

- **Physical barriers:** These are usually environmental factors, which disrupt or prevent the sending and receiving of messages, i.e. physical distance, distraction, noise, heat, and competing messages. This category also includes the physical disability of either the

sender or the receiver, i.e. being visually or hearing impaired, sleepy, tired, or ill.

- **Personal barriers:** These include social and psychological factors, which involve judgments, emotions and values held by both the sender and the receiver. Frequently, we see and hear what we want to; we consider the source and reject or accept the message. Personal barriers include bias, suspicion, rumors, customs, and taboos.
- **Semantic barriers:** These arise from different meanings and uses of words, symbols, images and gestures, including differences in verbal and visual literacy. Visual literacy is defined as an individual's capacity to extract the intended information or message from a photo or illustration.
- **Language:** The language in communication is very essential, especially in health communication. Often, health providers use medical terminologies or medical jargon while counseling clients. This constitutes a major barrier in client-provider interactions since clients most likely do not understand medical language. Health providers must use language that is most commonly understood by their clients. The more simple the language, the better the chance the clients will understand correctly.
- **Structural barriers:** These include social, political and economic barriers, which may affect how the message is transmitted and received. It can be related to who has access to information and who controls its use. As senders and as receivers of information, we need to be aware of the role we personally play in contributing to communication breakdown.

Impact of Barriers on Communication

- Leads to poor and wrong feedback
- Leads to conflicts of misunderstandings
- Leads to misinformation
- Leads to misinterpretation and misconceptions
- Leads to maladjustment
- Leads to an unfavorable attitude

How to overcome barriers to communication

- Use simple language
- Know your audience
- Use a good manner of speech
- Use appropriate messages
- Give the audience your full attention
- Use an appropriate channel/medium for your message

6. CONCLUSION

We may have to seize the opportunities presented to us in order to reach our goals. We may simply need to listen for those opportunities. We must recognize that inter personal communication is very powerful and allows health providers with unique opportunities that they can use to help others. However, communication is a process. Don't expect to have the

maximum impact the first time around!

Application

- Ask participants in what situation they can use acquired knowledge
- Ask for clarifications to ensure applications relate to learning

Evaluation

- What are the steps in behavior change process?
- What are the effect of poor IPC on the service, the provider and the community?

Summary

- Review the objectives of the session with the group.
- Link with the next session where you will look in more detail into IPC and Counseling.



Day 1 - SESSION 4

TOPIC: Introduction to Interpersonal Communication and Counseling (IPC/C)

TIME: Two hours

OVERALL GOAL: To help the participants learn the foundations of interpersonal communication.

OBJECTIVES: By the end of this session, participants will have:

1. Reviewed the role of interpersonal communication and Counseling (IPC/C)
2. Stated the elements of interpersonal communication and counseling (IPC/C)
3. Described the differences between IPC and Counseling (IPC/C)
4. Explained the 4 purposes of counseling
5. Explained qualities of a good counselor
6. Described factors that positively influence effective counseling

OVERVIEW: Participants will go through a series of discussions and exercises to understand the complexities of interpersonal communication and how it differs from counseling.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction	5 min	Group discussion	
2. The Role of Interpersonal Communication	15 min	Group discussion	Flip chart, Markers Power Point
3. Elements of Interpersonal Communication	30 min	Group discussion	Flip chart, Markers Power Point
4. Differences between IPC and	15 min	Group discussion	Flipchart, Markers

Counseling			Power Point
5. Meaning of Counseling	10min	Group discussion	Power Point
6. Purposes of Counseling	10min	Group discussion	Power Point
7. Qualities of a good Counselor	15min	Group discussion	Power Point
8. Factors that positively influence effective counseling	15min	Group discussion	Power Point
9. Conclusion	5min	Group discussion	

1. INTRODUCTION

Review the session objectives with the group. Ask participants if any areas need clarification.

For the client-provider interaction, our focus is on interpersonal communication.

The interpersonal communication process is a two way, interactive cycle in which the communicators exchange messages. All parties involved are both senders and receivers. In this process, the receiver interprets previous messages and responds with new messages. The messages communicated are both verbal and non verbal.

Good communication skills are as important as good clinical skills in providing high quality healthcare. Clients are more likely to seek timely care, cooperate with necessary procedures, follow through on recommendations and return for follow up care when they have trust and confidence in their providers. Developing a relationship of trust and confidence requires the ability to communicate well. Effective communication skills are therefore powerful and essential tools for all providers.

Verbal communication is more than the words themselves, and also involves the tone and volume of words. Tone can communicate compassion, hostility, anger or indifference.

Nonverbal communication can be as powerful, or even more powerful, than verbal communication. Providers must therefore be especially alert to the nonverbal message they convey. Besides the position and stance of the body, nonverbal messages can be communicated through hand shaking, laughing, gently patting, hand holding, eye contact (in some cultures) and facial expressions (e.g., frowning, furrowing brow, smiling).

Negative verbal or nonverbal communication can be a barrier to healthcare. Not only should providers be careful about the messages they are communicating through verbal and nonverbal means, but they must also pay close attention to the verbal cues and nonverbal behavior of other people.

Role play: Ask for 4 volunteers to do a quick role play, 2 will be the client and 2 will be the provider.

“Jamila is pregnant but doesn’t want to drop from school since this is her final year in secondary school. She went to an herbalist for help but the herbs made her sick and now she has come to you for help”.

Designate one ‘caring’ provider and one ‘non-caring’ provider. After the volunteers are finished, ask the group to point out the key differences.

2. THE ROLE OF INTERPERSONAL COMMUNICATION

Ask participants:

Are we producing satisfied clients who can then advocate for our programs?

Are we providing consistently high-quality services throughout the health system?

Lead a brief discussion based on the Trainer’s Notes below. This discussion will mention the elements of interpersonal communication.

TRAINER’S NOTES

Interpersonal communication is one of the key communication components influencing behavior change. The counseling setting is typically the critical juncture where individuals decide what behaviors they will adopt or will not adopt. Think back to the steps to behavior change (**slide**) and consider how an effective counseling interaction can move a client from intention to practice. The experience of a satisfied client is a powerful influence. How potential clients are treated during this critical point impacts greatly on those decisions.

Using what you know about your group, discuss at least 3 questions on each of the headings below with the participants:

Hospitality: Does your culture value hospitality? Probably yes! Yet, when you enter a clinic, are you greeted with a warm smile and welcoming words? When you leave the clinic, does the cashier thank you sincerely? What is your first and last impression of the experience? Would you send your own family members to that clinic? Hospitality, so valued by people, is part of high-quality interpersonal communication, and often missing in our IPC situations.

Consistency: Are the entire clinic staff trained in courteous, helpful behavior--from the receptionist through to the cashier? Does everyone maintain the same high standard? Is the same high standard maintained whether it is Monday, Tuesday or Friday? Are all clinics equally high quality or are some better than others? In effective IPC, we strive to provide consistent, high-

quality service both within a single clinic and among all the clinics. It means training everyone (including the receptionist and cashier) in effective IPC. It also means identifying what makes some clinics excellent and developing those characteristics to all clinics.

Satisfied Clients: Are we producing satisfied clients? How can we tell? Producing satisfied clients is truly the end goal of health communication. High dropout rates indicate a high level of dissatisfied clients--those who tried the new behavior and stopped for some reason. This is a dangerous situation because bad news often travels faster than good news. If you are dissatisfied, you tell everyone. We want satisfied clients to tell everyone the good news!

Definitions of Interpersonal Communication (IPC)

Ask participants for a definition of Interpersonal Communication, and then show the **slide** with the definition:

Interpersonal communication is a person-to-person, two-way, verbal and non-verbal interaction that includes the sharing of information and feelings between individuals or in small groups that establishes trusting relationships.

1. Interpersonal communication is influenced by the attitudes, feelings, values, social norms, and the environment of the people involved.
2. Interpersonal communication is an influential means for the adoption of a new health behavior and for the continued compliance with and maintenance of the health behaviors.
3. Interpersonal communication and counseling takes place in the health care setting and out in the field between health care providers and their clients, potential clients and members of the community and is a key element in maximizing access to quality care.

IPC can hardly be used as a method on its own to achieve behavior change. It is most effective when it complements, reinforces and elaborates messages presented using other channels such as the mass media. IPC is used everyday and good skills are essential in the workplace, interacting with colleagues, clients and customers, at home and in the community.

Interpersonal skills involve such care-related areas as communication, provision of a safe and comfortable environment, privacy and confidentiality, respect, and courtesy, all of which are vital to the effective performance of skilled providers.

Experience over the years has shown that IPC channels are most important when an individual is in the intention phase of behavior change – IPC channels can be the difference between that person actually moving to practice or not. Hence their importance in changing behavior cannot be overemphasized.

3. ELEMENTS OF INTERPERSONAL COMMUNICATION

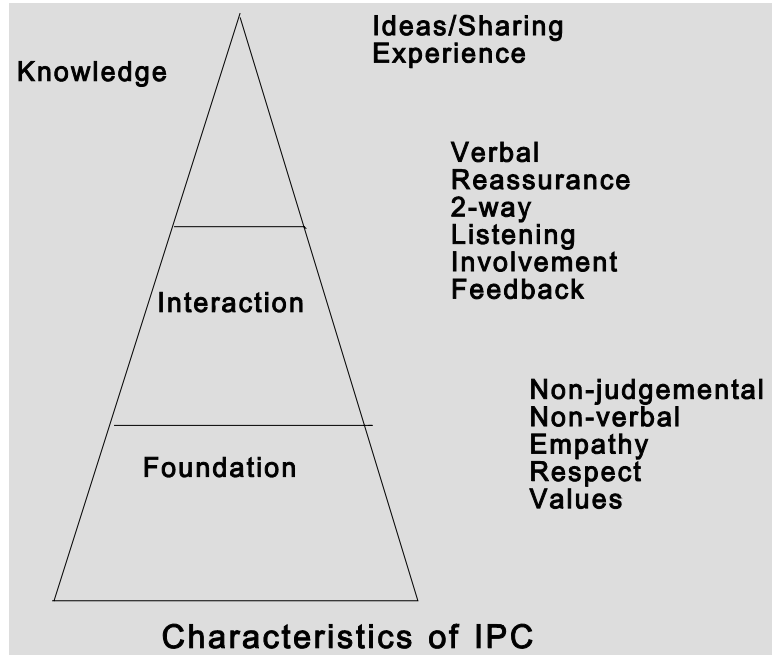
In pairs, ask participants to identify the elements of interpersonal communication. Ask for volunteers to share their responses.

Write their responses on a flipchart or blank transparency. Responses should include elements such as verbal, non-verbal, empathy, 2-way, respect, information sharing, knowledge, etc. Refer to the Trainer's Notes below.

TRAINER'S NOTES

Interpersonal communication is a skill we use everyday--at work, with our families, with our friends. We often think of it in terms of knowledge exchange, but there is much more happening than pure information sharing. Ask participants what they think about this.

Write the participant's ideas on a flipchart, and try to group them in three areas, Knowledge, Interaction and Foundation. Draw a pyramid next to it (see Characteristics of Interpersonal Communication). Sharing of ideas is just a small part of IPC.



Without a strong foundation and a good interaction, no knowledge will transfer.

The skills involved in building that foundation are the key to effective counseling. Effective counseling is like a gently guided or directed interview in which the provider, using these skills, prompts and encourages client discussion in a certain direction.

It is important for the service provider to see the link between his/her role and getting the client to change behavior.

4. HOW DOES IPC DIFFER FROM COUNSELING?

This section focuses mostly on the client-provider interaction. However, it is important to take the elements that make counseling effective and apply them to other types of IPC, such as husband-wife communication, couples and families communication and communication in social networks.

Counseling is the area we most think of using interpersonal communication skills. However, every one-on-one and small group interaction is interpersonal communication. Remember that interpersonal communication is 2-way communication, whether you are discussing safe birth planning adoption or you are discussing your decision with your family.

Ask participants to identify how they think IPC differs from counseling. Use the Trainer's Notes below to help bring out the key issues.

- Ask trainees to explain the meaning of counseling in their own words
- Record responses on FLIP CHART
- Acknowledge correct responses
- Put up **slide** with meaning of counseling and compare similarities and elaborate on correct responses

TRAINER'S NOTES

Counseling is a face-to-face communication where a provider enables a client to make an informed decision and act on it. Counseling is not advising. In advising, the provider takes more responsibility for the decision. In counseling, client makes voluntary informed choice or decision. This is after complete information is given.

Counseling and IPC are quite related. Most of IPC is used when counseling takes place but not all IPC is counseling. Most of the skills and attitudes needed for effective IPC also apply for counseling.

To be effective, counseling, for example, must be a two-way communication process, never simply "information giving," "instruction," or "informing."

COUNSELING:

"Face to face communication between two people whereby one person helps another person makes a decision or plan and act on it"

"Counseling is the process of one person helping another person make an informed, committed decision or solve a problem with an understanding of the facts and emotions involved."

Large group discussion

- Ask trainees to mention purposes of counselling
- Write trainees' responses on FLIP CHART
- Put up **slide** with purposes of counselling
- Ask trainees to take each point and explain in detail with regards to counselling for integrated health services

Counseling is undertaken in order to:

- Increase patronage of health facilities and utilization of services.
- Provide an understanding of available services and assist the client to make informed decision.

- Solve problems.
- Increase and maintain the level of satisfaction of clients about services received
- Promote acceptance of health services and encourage continuity.
- To reduce client's drop out rate.
- To help clients develop positive attitudes and maintain good health seeking behavior.

Large group discussion

- Ask trainees to mention qualities of a good counsellor
- Acknowledge correct responses
- Display **slide** with qualities of a good counsellor and explain/clarify

Qualities of a good counselor

- Knowledgeable
- Ensures confidentiality
- Good listener
- Shows interest
- Has self control and tact
- Non-judgmental
- Empathetic
- Honest and acknowledges limitations
- Approachable
- Ability to create rapport

- Ask trainees to mention and discuss factors that influence effective counselling
- Acknowledge correct responses
- Display **slide** with factors of effective counselling and clarify

Factors that positively influence effective counseling

- Conducive environment; privacy and confidentiality
- Showing concern to the client
- Being flexible and patient
- Accuracy and completeness of information
- Use of appropriate visual aids
- Readiness of the provider to assist the clients
- Positive attitudes of client towards the service provider's service
- Technical competence of the provider
- Positive attitudes of provider toward the subject to be counseled on

Ask trainees when they think counseling can be initiated

- Record responses on FLIP CHART

- Display **slide** “when to initiate counselling”
- Go through the FC and ask for clarifications

When to initiate counseling

- When providing either curative or preventive services
- When client has expressed a need
- When provider has identified the need
- When the timing is convenient to the client

Explain that for counselling to be effective it must be well timed and follow a process so that it is focused on clients’ needs. It is the goal of counselling to encourage the adoption of positive behaviors to promote good rapport between health providers and their clients. In order to have a good counselling interaction, the provider must be ready. What are some ways that you can prepare?

Record answers, then show **slide**:

Preparation for counseling

- Preparation of self
 - ✓ Assess self for readiness to help client
 - ✓ Be knowledgeable, have time, own values and beliefs about topic
- Preparation of counseling setting
 - ✓ Privacy – visual and auditory
 - ✓ Free from interruptions by other staff or other clients
 - ✓ Comfort – protected from sun, rain
 - ✓ Facilitation of free flow of information – face to face sitting, adequate light and ventilation
- Preparation of materials
 - ✓ All necessary and related visual aids should be gathered. For example, counseling clients with STI may lead to providing information about HIV/AIDS so material should be available to counsel for both

In the remaining sessions, you will work with the participants on all the skills associated with **Interpersonal Communication techniques applicable to a client provider interaction.**

By displaying slide let the participants know that these include:

- Active listening/being attentive
- Summarizing
- Paraphrasing
- Reflecting feelings
- Questioning
 - ✓ Open ended questions
 - ✓ Closed ended questions
 - ✓ Probing questions or statements

- Making positive statements
 - ✓ Praise
 - ✓ Encouragement
 - ✓ Reassurance
- Giving information
- Use of encouragers such as nodding or verbal language

5. CONCLUSION

Application

- Ask participants in what situation they can use acquired knowledge
- Ask for clarifications to ensure applications relate to learning

Evaluation

- Why is interpersonal communication so important to behavior change?
- How is good interpersonal communication particularly important for you as a health provider?
- What is the difference between IPC and Counseling?

Summary

- Review the objectives of the session with the group.
- Link with the next session where you will look in more detail into the skills that make up effective IPC/C



Day 2 - SESSION 5

TOPIC: *Summary of Day 1, ARH technical overview*

TIME: Two hours

OVERALL GOAL: To provide technical information for the trainees on the field of Adolescent Reproductive Health services

OBJECTIVES: By the end of this session, participants will have:

1. Defined what is Adolescence
2. Understood the unique physical and emotional needs of adolescents
3. Understood the ‘ABC’ of adolescents (Life Skills)
4. Understood ways in which a clinic can better accommodate those needs
5. Be familiar with methods for appropriate interaction with adolescents that make them feel welcome and want to come back! (Youth Friendly Services)

Notes for the Facilitator:

The first session of each day is relatively flexible – the technical overview will probably not take more than one hour, though there should be time for discussion. Feel free to use this time to recap the previous day, clarify any questions that may have come up overnight, or redo/review any exercise from the previous day that was not adequately completed or understood.

OVER VIEW OF ADOLESCENT REPRODUCTIVE HEALTH

Brainstorming

- Ask participants what they understand by adolescence
- Record responses on a flipchart
- Display **slide** with definition of adolescence
- Ask participants also, what are the common problems encountered by adolescents in their respective communities?
- Record responses on a flipchart and discuss

TRAINER'S NOTES

WHAT IS ADOLESCENCE?

Adolescence is the time when the young person changes and grows both physically and mentally from a child into an adult. During adolescence a lot of things start happening:

- Adolescence is a time when one becomes aware of him- or herself as a person.
- The body will change – in ways that the adolescents like and some that they don't.
- They start to have sexual feelings, and may not always know what to do about those feelings.
- They start to think independently and want to make decisions for themselves.
- Their feelings about family and relationship with parents may change – in good ways and bad.
- Parents are likely to give them more responsibilities, which is a nice sign that they trust and rely on them.
- But the parents might also start being very strict – keeping the adolescents from friends and trying to make decisions for them about their schooling or their future. Parents might also seem less affectionate towards them than before, and one may miss the easy, loving relationships he/she had as a child.
- Their friends – and what they (friends) think – may matter to them much more than they used to.

- Emotions may be much more complicated than they used to be, and sometimes they may not understand exactly the feeling they are having.
- They may really want to feel loved and to feel close to someone.
- They may face difficult decisions, and there may be times when they don't always know whom to turn to for advice.

Adolescence is a special time for everyone, everywhere, as well as a challenging time. This is a time of big change, and big changes take time. The youngsters face a lot of decisions as they go through adolescence, and some of the choices they make will stay with them for the rest of their lives.

There's a lot that they can do to get through adolescence safely. They can make sure they understand their body and the changes that are taking place. They can also make sure that they understand themselves and what they want out of life. It's important for them to take time to think about their future and to plan for it. Adulthood is a big responsibility, so they must prepare for it well during their adolescence.

Young people don't have to go through adolescence alone. They are surrounded by people who deal with serious problems on a daily basis. They have a large extended family – aunts, uncles and many cousins – to whom they can turn for advice. In addition, they are part of a rich culture, and they have rich traditions to draw on as they go through adolescence.

Adolescence has always been complicated everywhere, but today young people face problems their parents and grandparents may never have dreamed of, problems like:

- Pressure to have sex.
- Drugs in schools and the community.
- Parents who are too busy or shy to talk with their children about the changes they are going through.
- Sexually transmitted infections (STIs), including HIV/AIDS.
- Being orphaned because of AIDS or accidents.

- Wars and political instability.

To cope with all these things and to get through adolescence safely, they need to be strong, creative, resourceful and hopeful. It is important for them to try to learn from the people around them who are strong and calm in the face of hard times; to ‘take a page out of their book’ and try to cope with the challenges facing them with a positive attitude.

ABC of adolescent (Act-responsible; B- Be prepared; C- Consider the out come of your action), they are life skills with different terms “creative thinking” “problem solving,” “decision-making” and “self-awareness.” Life skills are very important. In fact, life skills are just as important as knowing the facts because the facts won’t protect the adolescents unless they have life skills too. For example, they may know that unprotected sex can lead to pregnancy, and STIs including HIV/AIDS, and they may have decided that they don’t want to have sex yet, but they don’t know how to be assertive with their boy/girlfriends and argue their point.

Because of the peculiar nature of adolescents, they need a youth friendly services which will allow them to open up for the provider to effectively assist them.

Youth Friendly Services are those services in which;

- You give adolescents warm welcome
- You make adolescents feel comfortable
- You respect the privacy and confidentiality adolescent client
- You give adolescent the same level of respect and treatment as your other clients
- You allow and encourage them to talk honestly with you about the challenges they face growing up.
- You recognize the specific needs of young people and their unique challenges, including the changes of puberty.
- You communicate information and services in ways that are easy to understand.
- You offer services in a non-judgmental manner, and counsel them for more informed decision-making about their health.
- Make adolescents want to come back.



Day 2 - SESSION 6

TOPIC: *Introduction to GATHER*

TIME: One hour, thirty minutes

OVERALL GOAL: To help the participants feel confident in training and reviewing with service providers the essential steps to effective counseling, the GATHER Approach.

OBJECTIVES: By the end of this session, participants will have:

1. Described IPC/C skills using the GATHER Approach.
2. Described six important steps in counseling.
3. Followed the counseling steps in a client-provider interaction.

OVERVIEW: In this session participants, will watch a structured role play for the group and will review the steps to follow during a client provider interaction.

BEFORE YOU BEGIN: You will need FOUR participants to do a role play for the group.
Choose volunteers and prepare them before the session.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction	15 min	Role play	Prepare two participants in advance for the role play
2. GATHER Counseling Process	60 min	Discussion Demonstration Role Play	Prepare two participants in advance for the role play Discussion guide
3. Conclusion	15 min	Discussion	

1. INTRODUCTION

Review the session objectives with participants and open the session by explaining we will begin with a short role play.

Role Play

Invite two participants (prepared in advance) to role play a short client provider interaction.

Ask the other participants to note the process, making a list of what the counselor does, such as:

- ❖ Greets by saying their name with a smile and body language that welcomes the client into the room.
- ❖ Ask the client, “What is the reason you came? How can I help you?” Reassure confidentiality and privacy.
- ❖ Ask medical history, lifestyle questions, etc.
- ❖ If appropriate, tells the client: Let me demonstrate how to use the condom and then proceed to demonstrate the use of the condom.
- ❖ Checks understanding regarding the reproductive health instruction just demonstrated, asks when client is returning.
- ❖ Says good bye.

End the role play after five minutes. Ask participants to describe the counseling process they observed. What worked? What didn't? Why not?

Make the point that it's important that the counseling process be organized. Effective counselors

follow a systematic process to help clients reach their health behavior goals.

Review the definition of counseling discussed earlier in the workshop [display slide].

Counseling is: the process of one person helping another make a decision or solves a problem with an understanding of the facts and emotions involved.

This definition features the following:

1. The role of one person (counselor) is to **help** another (client) take action. Final decision making is not the role of counselor.
2. Facts include what the client shares such as his or her medical history, family background, future plans and wishes, and partner's plans and wishes. Facts also include what the counselor shares, particularly accurate Reproductive Health information.
3. Feelings of the client include his or her concerns and fears, attitudes and values around sexuality, family planning, contraception and parenting.

2. EFFECTIVE COUNSELING PROCESS

- **Before this session**, ask two participants if they would act as clients in a role-play demonstration. Tell them that in each situation, the clients that they will portray are women who feel uncomfortable coming to the clinic. The women want information about temporary contraceptive methods that they can use to postpone pregnancy. But they know little about the different methods available.
- Post the GATHER acronym on flip chart paper in a place where everyone can see it.
- Post a list of qualities of a good counselor, too.

Role Play

Ask one of the participants who agreed to help with this role-play to join you at the front of the room (you may wish to have your co-trainer play your colleague, who enters the counseling area, interrupts the session, and distracts you. You pay attention to the colleagues, rather than the client).

Tell participants to imagine that the setting is a crowded family planning clinic. Role-play a counselor who violates the norms for counseling. Your manner is brusque. You are insensitive to the client's unease. You speak in a loud voice and are unconcerned about anyone overhearing you. You do not listen to what the client has to say and interrupt before determining her needs. You urge the client to adopt a particular method.

End the role-play after about 5 minutes, and explain that real-life counseling would continue but that the participants have seen enough to discuss the scenario.

Ask the person who played the client, “How do you feel about the family planning clinic and the counselor?”

Now return to the Role Play

Invite the second person that agreed to portray a client to come forward.

Now portray a counselor who respects the norms for counseling. You are sensitive to the client’s unease and respectful of the client’s feeling and need for privacy. You smile and are courteous. You listen to what the client has to say and are empathetic. You ask about the client’s reasons for visiting the clinic and what she needs. You assess what the client knows about contraception and provide brief information about different temporary method that she could use for birth spacing.

End the demonstration after 5-10 minutes, and explain that real-life counseling would continue, but that participants have seen enough to discuss the demonstration.

Lead a discussion using the tool below.

GATHER DISCUSSION GUIDE

After watching the role play, ask participants:

1. How would you describe the interaction between client and provider in each of the scenarios?
2. Do you think the client is likely to be a satisfied user of the method recommended by the family planning counselor in both scenarios?
3. In pairs, ask participants to discuss:
 - a. What did the provider do well?
 - b. What could the provider have done differently?
4. Ask some volunteers to share their answers.
5. Discuss the different steps of GATHER
 - G** greet
 - A** ask
 - T** tell

H help
E explain
R return

6. In pairs, ask participants to discuss how these steps differ from what they are currently doing?
7. Ask some pairs to share their discussion findings.
8. Explain that GATHER has proven a very helpful guideline for health care providers to follow during counseling interactions with clients.
9. Ask participants what advantages they see in following the GATHER approach in their daily work.
10. What are the disadvantages that participants anticipate in following the GATHER approach?

TRAINER'S NOTES

Effective counseling consists of six steps, described by the word or acronym: **GATHER**

GREET the clients (establishing rapport)

Note previous comments on respect and friendliness.

ASK clients (gathering information)

Refer to the previous trainer's notes on the importance of eliciting the needs of the clients and prioritizing information to make it more relevant. Asking is more than medical history because other aspects of a person's life (life stage, lifestyle, personality, etc.) often impact the client's post-counseling behavior more than his or her medical history.

TELL (provide information)

Specific information, organized logically is retained longer and more fully, especially if the client is encouraged to ask questions. Avoid information overload such as reciting details on all the procedures you are discussing because there is a limit to how much information people can retain. Instead, group the information and then check for understanding.

HELP the client

This is the decision-making or problem-solving moment. The provider is helping the client sort through the medical information and lifestyle and life stage issues to come up with various alternatives and helping the client consider each alternative for its advantages and disadvantages.

The client makes the decision.

EXPLAIN to the client

Once the client has made a choice, the provider uses client education material to help the client remember key information specific to that decision. The provider also uses IEC materials to remind her or him of important discussion points. IEC materials reinforce key information – mention that we will specifically work with these kinds of materials in the next section. One example is family planning methods, where this would include:

- ❖ effectiveness
- ❖ side effects and complications
- ❖ advantages and disadvantages
- ❖ how to use
- ❖ when to use
- ❖ STD prevention

For PAC, some examples would be how long to wait to have sexual intercourse, nutritional information for recovery, and safe contraceptive methods for a woman to use after and abortion etc.

RETURN/REFER/REALITY CHECK

Return visits or referrals should be planned. Clients need advice concerning when to return for follow-up or re-supply. This is also a good time to do a reality check with the client. Make sure they can apply what they've learned in the meeting to his or her real world environment.

Not every counseling session consists of all six of these elements or in this order. Some may simply involve repeating certain elements. Every counseling situation should be tailored to the client's needs. Continuing clients, in particular, have specific needs that should be met with specific responses. Clients often talk with counselors several times before they decide to act. A counselor should be prepared to see the client as often as the situation demands.

3. CONCLUSION

Once all groups are finished, bring everyone together in the plenary. Ask participants about their experience. What went well? What would they do differently next time?

Application

- Highlight the major lessons and points in the session. Invite participants to share their reactions and thoughts.
- Ask participants what new ideas they have learned or perhaps lessons they have remembered as a result of the session.
- Ask what behaviors they think will be easy to put into practice and what do they think will be difficult.

Evaluation

- What does the acronym GATHER represent?
- Ask participants to say in their own words how the GATHER steps sums up effective counseling

Summary

- Review the objectives of the session with the group.
- Link with the next session where you will get the participants thinking about how their own biases affect their counseling.

Day 2 - SESSION 7

TOPIC: *Values Clarification*

TIME: One hour, thirty minutes

OVERALL GOAL: To help the participants learn the foundations of interpersonal communication.

OBJECTIVES: By the end of this session, participants will have:

1. Listed factors that influence perceptions, values and attitudes
2. Discussed values, in relation to the health issues of the intervention areas.
3. Clarified values in relation to Safe motherhood, Birth spacing, PAC and ARH.
4. Explained the role of the providers' perceptions, values and attitudes during IPC/C

OVERVIEW: Participants will perform exercises that give them the chance to look at their own values. By revealing their personal biases, they will better understand the importance of providing services for clients without judgment, and be better able to separate a clinical interaction from their personal beliefs.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction	10 min		Flip Chart, Markers
2. Perceptions, Values and Attitudes	25 min	Group Discussion and Exercise	Put large signs on 2 walls: "Agree" and "Disagree"
3. Definitions, Differences, Factors	25 min	Group Exercise	Flip Chart, Markers
4. Clarifying Values	20 min	Group Exercise Discussion	
5. Conclusion	10 min	Presentation,	

1. INTRODUCTION

- Trainer introduces the topic and reviews objectives with the group.

Values are often so ingrained that it's possible not to be aware until one is confronted with a situation that challenges such values. When a service provider understands his/her own values, he/she will be better able to appreciate the various experiences that shape the client's values.

It is necessary that the facility and the community providers are aware of all these perceptions most of which are negative and false so as to be better placed to address these issues and provide correct and factual information that will be beneficial to the client and assist in the uptake and completion of services required.

2. PERCEPTIONS, VALUES AND ATTITUDES

Before the exercise on opinion poll below;

1. Ask 2 or 3 participants to share with the group what they value most in life and what helped them to form that value system?
2. Ask each of them to describe his/her feeling if someone ignores that value?
3. Then tell them that the opinion poll exercise will help us to explore our various value systems and how they affect the way we interact with our clients.

Opinion Poll

Ask participants to note two signs posted on the opposite walls, AGREE and DISAGREE Ask participants to stand. Explain to trainees that you are about to take a poll of their views with respect to issues in the intervention areas. Tell them you will read a statement and they are to move to the sign Agree or Disagree that reflects their opinion. Explain the exercise as follows:

- There is no right or wrong answer to any question.
- They must either agree or disagree with each statement – they must make a choice, so don't let people stand in the middle.
- If they agree with the statement, they should stand on the side of the room "agree", if they "disagree", they should stand on the side of the room with the "disagree" sign.

Read statements from the List of Opinion statements in page 71. Allow participants time to think and move.

Once settled, ask a few participants from each sign area to explain the reasons behind their choices. Remind everyone that there are no wrong or right answers, only opinions.

Repeat the process 6-8 times as time permits. Wrap up the exercise by asking the following questions:

1. What was most striking to you when you did this exercise with regards to:
a) Yourself? b) Others?
2. Were you surprised by the responses of your peers?
3. How did you feel when others disagreed with you?

We all have our own perspectives and opinions. These opinions and perceptions are not necessarily right or wrong, they just are. Likewise, clients have their own perceptions and opinions. Understanding these can give us insights into why our clients make decisions and practice health behaviors.

TRAINER'S NOTES

People are a complex mix of unique characteristics which include physical characteristics and emotional characteristics: perceptions, values and attitudes. This session focuses on how one's own personal view of the world can help or hinder one's ability to help clients make health decisions.

Key points to emphasize as you go:

- When trying to communicate there will be many perspectives to the same issue.
- There is no 'right' or wrong perception.
- Similar background, level of education does not guarantee that variations in values will not arise
- When providing services, the service provider should not assume to know what client's perspectives and values are about his or her health situation. It is essential to find out what they think, feel and know about health conditions in order to provide appropriate information and or service.

3. DEFINITIONS, DIFFERENCES, FACTORS Perception, Values and Attitudes

Take three pieces of flipchart paper, and write one word in each paper: perception, values and attitudes on top of the page. Ask for volunteers to define the meaning of the three words. Write their responses.

Without reading through all this text, try to help participants categorize their responses based on the following definitions:

Perception: to perceive is to become aware directly through the senses, to achieve understanding. Thus, perceptions lead to insight, intuition, or knowledge.

Values are the social principles, goals and standards held by an individual or group that influence the individual's daily life activities or a principle, standard or quality regarded as worthwhile or desirable.

Attitude is a state of mind or a feeling. It is the mental position we as individuals take in relation to the world. Attitudes are largely based on our personal values and perceptions. Attitudes are mental views, opinions, dispositions, postures, or behavior.

EXERCISE: The differences among the concepts:
Ask participants to imagine a camel that is behind a high fence.
Without speaking, ask them to consider what they see.
Have them write their responses.

The camel: Values, attitudes and perceptions can be imagined as a camel hidden behind a high fence. Although one may only see the top of the hump sticking out over the top, in truth on the other side is a large camel on which that hump is based. Use the **slide** to illustrate this point.

The same is true of attitudes, values and perceptions. That which we present to the world are our attitudes and they appear to stand on their own. Yet they are based on a large set of often unspoken underlying values and perceptions. If those underlying values and perceptions were different, it is most likely that our attitudes, our view of the world, would be different. Just as if the camel's body was, in fact, a cow, the hump which the world sees would be different. Therefore, in order to change one's attitudes, it is important to become aware of the perceptions and values that lie beneath the surface.

Discussion

Divide participants in pairs and ask them to discuss:
When are values formed?
Where do we get our values?
Why is it important to clarify our personal values?

Write participants' responses on flipchart paper.

When are values formed? In childhood. The "formative years" are so called for good reason.

Where do we get our values? We inherit many of our values from our family. Other

influences include traditions, media (TV, music, videos, magazines, and advertisements), school, cinemas, climate, environment, technology, politics, personal needs, economics, religion, friends, education, cultural factors, and personal experience. Values are beliefs, principles and standards to which we assign importance. They reflect parts of our lives we prize and give a degree of significance. Our values are often so ingrained that we are unaware of them until we are confronted with situations that challenge them.

Note: Throughout this session it is important to look for opportunities to relate values, attitudes and perceptions to the situation of the participants and their clients.

Values clarification means sorting out one's own 'real' (intrinsic) values from the values of the outside world (extrinsic) -- separating one's personal beliefs from the beliefs of others. It means saying what we really mean.

Why clarify values? Each person creates a unique mix of perceptions, values and attitudes that makes up a personal cultural identity. By understanding our own values, service providers can appreciate and respect the various experiences that shape the values and belief systems of their clients. By appreciating our own perception and attitudes towards reproductive health (RH), we recognize that they may differ from our clients'.

PERCEPTIONS

Tell participants we are now going to focus on PERCEPTIONS, the deepest waters of our minds and where we usually have the least awareness.

Ask participants to close their eyes and imagine an old woman.

Ask them to open their eyes and write a description of old woman they imagined.

Ask for volunteers to share their descriptions and write the responses.

Responses will show a variety of characteristics of the old woman descriptions of her appearance, situation, state of mind, her needs or her concerns.

- What led to such a variety of answers?
- Discuss and summarize based on the Trainer's Notes.

TRAINER'S NOTES

Our perceptions are affected by our age, gender, social class, ethnic background, life experiences, etc. We may think that we see somebody clearly but personal perceptions influence or color our vision, as though we are wearing colored eyeglasses. As a result, no two people perceive something/somebody exactly the same.

4. CLARIFYING PERSONAL VALUES

People see things differently due to a variety of factors - background, gender, age, social and cultural beliefs, personality, level of education, religion, etc. - clarifying our own values and perceptions of the world can help us understand what may influence our interactions with clients. Tell participants that we will now do an exercise to better understand how our perceptions and values affect the client-provider interaction.

Partner Assessment Exercise

This exercise is to be done without talking to each other.

The facilitator will:

1. Ask participants to form pairs. Ask them to sit down together.
2. Without talking with their partner, ask each one to write 10 words they feel define who they are (e.g. mother, wife, caring, intelligent, strong-willed, athletic, funny, hardworking, etc.).
3. Ask them to write 10 words they feel define their partner.
4. Lastly, ask them to write down what their partner's Reproductive Health needs are.

Once completed, they are to share and discuss their lists and needs assessment with their partner. Were they accurate in their assessment of their partner? Maybe yes, maybe no.

- (A) Did anyone correctly or almost correctly identify the characteristics of his/her partner? If so, how do you think this was possible?
(Possible responses:
❖ similar educational background
❖ same sex
❖ same cultural background
❖ same religion
❖ knew each other before
❖ had discussed this before
❖ had observed him/her previously)
- (B) Why do you think some of you did not identify the characteristics of your partner correctly?
(Possible responses: Even though you know someone you may still be unaware of how that person views him/herself unless special efforts are made to learn this, possible stereotypes.)
- (C) What would have assisted you in correctly identifying your partner's characteristics?
(Possible response: If participants had been allowed to talk together.)
- (D) How did it feel to be told what/who you are? Did you feel prejudged or misjudged? Or perhaps you were flattered? What was your reaction?

(Possible responses: Felt resentful, surprised, happy, misjudged, amused, lost/gained respect of person making assessment. Perhaps it was more difficult to then tell the truth or felt need to defend self.)

Teaching Point: Why is this exercise important?

- Supposing your clients had the opportunity to list their major problems in order of importance how would these resemble your own ideas of their problems?
- How can we become more familiar with the value systems and ideas of our clients and their families in order to communicate more effectively with them?
- Highlight that what we value influences our attitudes towards people, behaviors, situations and things and remember the factors that affect our values.
- The power of personal values: personal values influence how we view ourselves and how we view others.
- We must clarify our own values first: to change others we may have to change ourselves first.
- We must have empathy for others: step into the shoes of our audience
- We must have respect for differences in order to build rapport and trust
- We cannot ASSUME anything!
- If you had difficulty in guessing a fellow participant's real interests, think how even more mistakes might be made about the needs and concerns of the client about whom you may know very little.

This exercise helps participants focus on the problems and interests of their clients and their families. This activity has demonstrated how difficult it is to make assumptions about someone else's interests and how easy it is to make incorrect assumptions.

TRAINER'S NOTES

As service providers, it is often difficult to assess quickly what are our client's values, attitudes and perceptions. However, if we do not understand our clients, we risk misleading them, helping them make a decision they don't feel comfortable with, or they are not ready to make or even losing them.

Research shows that family planning users are much more likely to continue using if they made the final decision themselves. We accept that family planning decisions should be based on informed choice by the client. Therefore, it is the service provider's responsibility to understand the client's values, attitudes and perceptions as much as possible to facilitate their informed decision-making.

5. CONCLUSION

Application

- Ask trainees after expressing their feelings what they have learnt.
- Ask how they will apply this knowledge to their work situations.
- Acknowledge applications.

Evaluation

- Why is value clarification important to the work of service providers?
- How can we appreciate the value system of our clients?

Summary

- Revisit session objectives and check to what extent they have been met.
- Explain knowledge gained here will be applied while providing services to clients.
- Thank trainees for their participation and declare end of session.
- Introduce the next session.

Opinion Statements

1. Girls should be virgins when they marry.
2. Most women want sex less often than most men (most men want sex more often than women)
3. For a breast-feeding woman, sexual intercourse has bad effects on the baby who is breast-fed.
4. Safe Motherhood does not involve men as much as women.
5. Exclusive breast-feeding results in babies having constipation and tummy problems like wind.
6. Contraceptive use encourages promiscuity.
7. Sex workers (prostitutes) provide a useful social service.
8. It is possible for a man to be in love with more than one woman at the same time.
9. It is possible for a woman to be in love with more than one man at the same time.
10. It is OK for a woman to use a contraceptive method without informing her husband.
11. Sex and sexuality should be taught in secondary schools.
12. Pregnant teenagers should be allowed to continue in school.
13. Husbands should never hit their wives.
14. It is a girl's fault if she becomes pregnant.
15. Polygamy is a family planning method.
16. It is best not to allow TBAs to handle deliveries because they are mostly illiterate.
17. The community can play a tremendous role in safe motherhood and prevention of obstetric emergencies
18. Most service providers do give friendly care to adolescents; they are generally treated with respect.
19. Service providers have answers to all client and community health problems all the time.

20. A Safe Delivery Plan is the surest way to prepare a woman for any emergency associated with pregnancy and delivery.
21. Birth spacing methods contribute to preventing unplanned and unwanted pregnancies.
22. Service providers have no business attending the social events in the community where they work.
23. It is an abomination for a woman to ask her husband for sex.
24. Any service that is free of charge is likely to be inferior.
25. The choice to space children is a collective one between a husband and his wife.

Day 2 - SESSION 8

TOPIC: *IPC/C Skills: Observation and Establishing Rapport*

TIME: Two hours

OVERALL GOAL: To develop fundamental communication skills of observation and rapport building which impact the client-provider interaction.

OBJECTIVES: By the end of this session, participants will have:

1. Described the importance of observation and rapport in client-provider interaction.
2. Identified the areas of observation.
3. Explained four ways to establish a positive client-provider relationship.
4. Practiced observation and establishing rapport during client-provider interactions.

OVERVIEW: Participants will learn and practice 2 key skills for effective communication: observation and rapport building. They will learn why these skills are key and how to use them appropriately.

BEFORE YOU BEGIN: You will need to prepare two participants to do a short role play to start the session. See the introduction for details, and find volunteers far enough in advance for them to be ready.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction	20 min.	Role Play	
3. Observation	45 min.	Discussion, GATHER Video, Individual Exercise	Video/Monitor GATHER Video Cassette Checklist
4. Establishing Rapport	45 min	Discussion, Pair Exercise, Practice Rounds	Checklist

5. Application and conclusion	10 min.	Discussion	
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1. INTRODUCTION

Tell participants you want to begin with a short role-play. They are to observe what happens.

Before the session, ask two participants to role-play a scene of a teen asking her parent (mother or father) permission to go and spend the evening with friends. The parent should be reluctant (Don't you have schoolwork to do? Don't you have housework to do? etc.). The teen should plead to be allowed to go (She's my best friend, schoolwork can wait, housework can wait, etc.). Allow the role-play to go on about 5 minutes.

Ask the participants to share what they observed regarding body language, tone of voice, words, non-verbal cues, etc. What did their observations tell them about the interaction?

Ask participants to explain how this relates to the client-provider interaction. What happens if a client is unhappy about the way she was treated by the service provider?

What are the consequences for the client? What are the consequences for the provider?

(See Trainer's Notes)

Introduce the session by explaining that the skills of observation and establishing rapport are the foundation of the client-provider interaction. In this session we will explore these skills and increase our ability to "notice" what is happening around us.

TRAINER'S NOTES

Attaching meaning to our environment is an automatic, daily process. Most people don't separate the activities of gathering information (typically through the senses--hearing, seeing, touching, etc) and the act of making interpretations about it.

Our ability to separate these two processes decreases stereotyping and allows us to see the client as a unique individual. It is very likely that some participants will have difficulty understanding the difference between the information and the interpretation.

When you hear an interpretation (the counselor was angry, or the client was happy), it is important to ask the participant what they saw or heard that led them to that conclusion.

Remember the list from Session 4:

- Active listening/being attentive
- Summarizing
- Paraphrasing
- Reflecting feelings
- Questioning
 - ✓ Open ended questions
 - ✓ Closed ended questions
 - ✓ Probing questions or statements

- Making positive statements
 - ✓ Praise
 - ✓ Encouragement
 - ✓ Reassurance
- Giving information
- Use of encouragers such as nodding or verbal language

These counseling skills (for example: questions, reflection of feeling) are single communication behaviors. This approach to training counseling focuses on breaking down the complex interaction into small behaviors. Research has confirmed that mastering these components and then integrating them into the complex counseling process, is a powerful and efficient way to learn. In counseling skills training, practice is the most important dimension of the program.

2. OBSERVATION

Tell participants that we will begin with observation skills.

Some of the ways people communicate with each other are words, voice tone, body movement, touching, facial expression, eye contact, and clothing. Even items like houses, furniture, etc. reflect a person's values, perceptions and attitudes. Of these, much can be learned by paying close attention to non-verbal cues. They often give deeper insights into true thoughts and feelings.

Ask participants for examples of the differences between verbal and non-verbal communication.

Example: Verbal: Yes, yes, I have time.....
 Non Verbal: Looking at the watch several times during conversation.
 Not sitting down in the chair.

Describe the two parts of observation:

1. Noticing - What you actually see and hear
 Verbal and non verbal messages
2. Interpretation - Giving your speculation about what you observe; attaching
 meaning

The counselor wants to observe a client's verbal and nonverbal behavior with an eye to identify discrepancies and mixed messages. What do you see, hear, and feel from the client's world?

The counselor organizes the information into three major areas:

1. **Client non-verbal behavior:** Eye contact patterns, body language, and vocal qualities are all important indicators that tell us what is going on inside the client.
2. **Client verbal behavior:** When does the client change topics? What are his or her key

words and descriptions?

- 3. Client discrepancies:** An observant counselor will notice when there are conflicts between verbal and nonverbal behavior, between two statements, between what the client says and what they do.

Exercise:

Ask 5 participants to role play a scenario, 1 of them will act as a doctor, and 2 of them will act waiting in a clinic waiting room. The other 2 will come and join them. The 2 women sitting in the waiting room start telling the other 2 who entered about contraceptive methods, but their explanations are exaggerated, not telling them the right information. They mention the doctor's plastic gloves, creating a very unpleasant picture of the examination that a doctor must perform before giving a client an FP method.

One of the women in particular is listening and clearly nervous based on the conversation.

The doctor now comes out for the listening client and she is considering not going in, but the rest tells her she has to at least go in.

The doctor opens by saying, "it's almost lunch time you know...."

"Have you had family planning before?" Client says-no!

Doctor- orders nurse to get a speculum.

"Have you heard about the kinds of contraceptives?" Client says-no!

Doctor ask client to speak up! Telling her that there are many types, listing them without any explanation. Mentioning a lot of technical terms, asking the client "Do you understand?" There has been no any clarification.

The doctor continue asking the client, when did you copulate with your husband last? When did you see your menses last? He now puts on gloves. The client gets scared, since the doctor didn't tell her what he is going to do.

Client says that she is going to ease her self in the toilet and she leaves without coming back.

The doctor is surprised that the client is very scared and runs away from the family planning clinic.

Ask the participants to use the observation checklist in their manual (page 81). Ask them to fill in the two columns of the observation sheet while watching the scenario.

In the "Noticing" column, they should describe in clear, behavioral terms what they SEE and HEAR during the scenario.

In the "Interpretation" column, they should give their explanation about what they observe (Example: Client feels anxious, is upset about something, does not understand the provider etc.).

After the scene, ask for volunteers to share examples of what they wrote. Process the exercise by asking about the experience. What was difficult?

Discussion

In pairs, ask participants to brainstorm the reasons why observation is important to client-provider interaction. Ask some volunteers to give their answers. Write responses on a flipchart.

Explain that it is important for service providers to observe and make interpretations of everything they see and hear from their clients during client-provider interactions, including verbal and non-verbal behaviors, to identify discrepancies and mixed messages. Make the point that good observation skills prevent us from jumping to conclusions.

3. ESTABLISHING RAPPORT

Discussion

We are now moving to another IPC Skill: **establishing rapport**. Ask participants how they would define rapport. (Comes from the French language)

Possible responses:

- ❖ establishing a relationship that is harmonious or sympathetic
- ❖ implies building trust
- ❖ liking one another
- ❖ having each other's best interest in mind
- ❖ mutual respect

Building rapport shows the client that the provider is paying attention to him/her. The client is the most important person for the provider at that moment.

Ask participants why "rapport" is important to client-provider interaction.

Possible responses:

- ❖ Establishing rapport is essential to the helping process.
- ❖ Without rapport, the client is less likely to express herself adequately.
- ❖ Client may be less likely to understand the information or comply with the provider recommendations, follow through on any decisions made in the meeting, or return to the service site in the future without rapport.

Creating a Partnership Exercise

Draw a House Exercise:

Ask the group to pair up, each pair sharing one pencil and one piece of paper. Without talking, they are both to grasp the pencil and draw a house together.

Ask the group to show their house and share their experience. Ask who was the leader? Who was the follower? Were you focused on the goal of drawing the house (task-oriented) or on

getting along with your partner (relationships-oriented)?

Teaching Point: Good counseling is a balance of building relationships and achieving tasks. Without good rapport, tasks are very difficult to achieve.

Discussion

Ask participants to think about what service providers do to make sure that the client feels comfortable and feel that the provider is truly concerned and interested.

Possible responses:

<ul style="list-style-type: none">❖ Greet the client in a friendly way❖ Be patient❖ Don't interrupt, respect the client as a human being with dignity❖ Smile, make eye contact❖ Make encouraging remarks❖ Avoid being judgmental❖ Observe body language	<ul style="list-style-type: none">❖ Listen attentively❖ Use open-ended questions❖ Summarize statements❖ Maintain privacy and confidentiality❖ Respond to non-verbal cues❖ Ask reasons for the visit❖ Ask about feelings
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Participants can remember key points to keeping your non-verbal cues on the right track with the acronym ROLES. Use these to remind yourself of ways to show the client that you are listening attentively:

- **R = Relax**
- **O = be Open and approachable**
- **L = Listen and lean towards client**
- **E = make Eye contact**
- **S = Smile**

TRAINER'S NOTES

There are additional ways in which the service provider can establish rapport during the interaction with the client.

Additional Rapport Building Skills:

1. **Showing Positive Regard:** Being respectful and showing positive regard results in less counselor talk, more client talk.

Environment is an influential factor in effective interpersonal communication. Besides ensuring that the woman has a safe and comfortable physical environment, the provider should try to create an environment that is culturally and emotionally safe and comfortable as well. Examples of factors that should be considered in the cultural environment are: gender preference in providing healthcare,

purdah, language and culture of the provider (if different from client), traditional food customs, beliefs about blood transfusions, values and ideals related to modesty, and customs. Lack of regard and respect for cultural values can become an obstacle to receiving care. Negative attitudes of providers can frighten away women in need. Providers should therefore respect clients' culture, values and beliefs, even when unfamiliar to them.

2. **Creating a Partnership:** The Draw-a-House exercise can be used to introduce the topic of the role of the counselor as expert partner to the client. This is an example of sharing that is crucial in the helping process. The provider needs to stop dominating the conversation and the decision making while focusing on facts in order to empower the client and build rapport.
3. **Making Positive Responses--Praise, Encouragement and Reassurance:** Clients need to know that the counselor has heard what they have been saying, seen their point of view and felt their world as the client experiences it.

Encouragers are a variety of verbal and nonverbal means the counselor can use to prompt clients to continue talking. They include head nods, an open-handed gesture, a phrase such as “uh-hum,” and the simple repetition of key words the client has said. Making positive statements can help clients feel good about themselves. When a client is in a crisis, it can help him/her to get control of his/her own situation. Avoid giving false praise. Some examples are:

Praise: You are looking well today.

Encouragement: Coming here whenever you have a question is a good idea.

Reassurance: A lot of people have that same concern. Being HIV positive does not mean that you are going to die today

Providers who are successful counselors work in an environment in which everyone treats clients with **respect**. Research says that clients are more likely to be satisfied with services if all staff treats them with respect and friendliness. Poor counseling is associated with discontinuation and method failure. Respect and friendliness includes the assurance of privacy and confidentiality.

Effective providers are able to personalize the interaction. They respond to each client's individual needs. Needs are based on the client's lifestyle, life stage and personality.

Ask for volunteers to make positive responses to the following statement:

I had unprotected sex last week, now I have a discharge.

Sample responses:

It is good that you came early so that we can discuss it.

Oh, it must be uncomfortable for you!

Ask participants to share situations where a provider will need to encourage, praise or support a client. Ask the participants:

- a. Was it difficult to think of something positive to say?
- b. How do you think it might feel to have someone give you a positive response in a situation where you are worried?
- c. When is praise appropriate?
- d. When is encouragement appropriate?

Point out that in real life, a variety of interpersonal communication techniques must be used. The skill is in knowing when to use each one.

Establishing Rapport Practice

Introduce participants to the GATHER self-assessment tool. Remind them that they are already very familiar with the GATHER steps, and that each of the specific skills that we are now presenting fits neatly into the GATHER framework. Ask them to focus just on the 'G' in the following exercise.

In groups of three, each participant will take turns acting as a provider, a client and an observer. Provider and client should role-play the following scene: Client who is visiting the clinic for the first time.

The observer uses the GATHER checklist

After 3-4 minutes of role-play, the observer should give feedback (1-2 minutes) to the provider on what happened positively and on what could be improved. Then the three group members should switch roles and repeat the exercise. After the second role play, switch roles and repeat a third time. At the end, each group member has played a provider and a client and has observed.

Facilitator can visit and guide each small group during the practice.

When the practice is over, bring everyone back to the large group and process by inviting volunteers to share the experience (what they observed, what they felt, etc.). Ask participants whether the practice was useful and why

4. CONCLUSION

Summarize the experience gained from the individual exercises. Point out that a variety of IPC techniques must be used. The skill is in knowing when to use each one.

Application

- Ask participants to volunteer sharing one important personal lesson they learned in this

session (or a reminder of something they've forgotten).

- Ask participants in what situation they can use acquired knowledge
- Ask for clarifications to ensure applications relate to learning

Evaluation

- What are some of the individual skills that make up effective counseling?
- Why are observation of a client and building rapport with them important to improving the health of the client?

Summary

- Review the objectives of the session with the group.

Link with the next session where you will look in more detail at other skills like paraphrasing, summarizing, and appropriate questioning of a client.

OBSERVATION	
NOTICING	INTERPRETATION

TRAINER'S NOTES

Remember – this is the assessment that providers will use to score themselves when they return to their sites. They should substitute “The provider” for each time “I” appears as it is currently written. The goal is for them to give constructive feedback to their colleague, and become adept at using the tool.

NAME: _____ DATE: _____	SCALE: Always = 5 Usually = 4 Sometimes = 3 Rarely = 2 Never = 1
AREAS OF COMPETENCE	SELF-SCORE
G is for GREET (this includes establishing rapport, and observing the client throughout the session with them)	
I greet the client respectfully and warmly	
I ensure the counseling environment is private and comfortable	
I use eye contact in a natural and culturally appropriate	
My facial expression communicates caring and interest	
My gestures communicate caring, interest and acceptance	
My body posture is natural, relaxed and attentive	
I assure confidentiality	
A is for Ask	
I ask reason for visit	
I can follow or “track” what the client’s saying or the client’s topic	

I do not interrupt	
I ask one question at a time	
I refrain from leading questions or cross-examining	
<p>I use counseling skills effectively (try to score each of these):</p> <ul style="list-style-type: none"> • Paraphrasing • Summarizing • Reflecting feelings • Open-ended questions when appropriate • Closed-ended questions when appropriate • Use of Encouragers (praise, reassurance, encouragement) to foster dialogue 	
I use appropriate non-word noises that encourage client to talk	
I pay attention to the client's nonverbal cues (glances, gestures, bodily reactions, voice tones, pauses) and make adjustments to my style based on them	
I pay attention to the client's verbal cues (content, voice tones, pace)	
My rate of speech communicates empathy, caring, interest, involvement	
I am comfortable with managing silence	
T is for Tell	
I am not judgmental	
I respect the client's opinion	
I respond directly and completely to client's questions and statements	
If the client brought up a rumor, I respond with accurate information.	
I legitimate the client's concerns and anxieties	
I explain technical concepts in words the client can easily understand, and relate them to the client's personal situation	

I invited the client to tell me whenever he or she did not understand something.	
I checked to be sure that the client understood and remembered technical information.	
I feel prepared technically about issues relevant to the client, such as :	
a. ----- Sexuality (post-abortion care, safe motherhood)	
b. ----- If young (physical changes during youth)	
c. ----- Relationships (family, peers, work/school)	
d. ----- STDs/HIV/AIDS	
I am comfortable talking about things related to sex	
I provide information that is directly tailored to the client and his/her circumstances and needs. If a client needs more information than I can offer, I know who to refer them to, or other resources to find the information	
I am comfortable using IEC materials appropriately	
H is for Help	
I invite the client to ask questions	
I help client to identify problems and solutions	
I refrain from offering sympathy or solutions prematurely	
I let the client do most of the talking	
I keep the client focused for a discussion relevant to their specific situation	
I identify accurately and communicate understanding of client's feelings	
I use my counseling micro-skills to <u>carefully</u> clarify any areas where the client may be vague or contradictory in their answers.	
I assist clients to develop options	
I assist clients to examine consequences of each option	
I let the client make the decision	

E is for Explain

I am able to present a concise, accurate and timely summary of themes presented by the client

I confirm any decisions or choices by client; checking commitment

I guide the client in thinking through his or her choice and adopting related behavior change

I demonstrate knowledge of support and referral resources

R is for Return

I encourage the client to return for follow up as necessary, if he or she has any questions, or if he or she experiences any problems.

I invite the client to bring or send others

I thank the client for coming

NOTES:



Day 3 - SESSION 9

TOPIC: *Summary of Day 2, PAC technical overview*

TIME: Two hours

OVERALL GOAL: To provide technical information for the trainees on the field of Post-Abortion Care services

OBJECTIVES: By the end of this session, participants will have:

1. Understood what is abortion
2. Understood the difference between various types of abortion
3. Understood the factors responsible for abortion
4. Known the signs and symptoms of unsafe induced abortion
5. Understood the important danger signs of complication from abortion
6. Became familiar with the key components of Post Abortion Care (PAC)

Notes for the Facilitator:

The first session of each day is relatively flexible – the technical overview will probably not take more than one hour, though there should be time for discussion. Feel free to use this time to recap the previous day, clarify any questions that may have come up overnight, or redo/review any exercise from the previous day that was not adequately completed or understood.

The next session is a long one, and so it should be started as part of this session once the technical overview has been completed.

OVER VIEW OF ABORTION AND POST ABORTION CARE

Brainstorming

- Ask participants what they understand by abortion
- Record responses on a flipchart
- Display **slide** with the definition of abortion
- Clarify any doubt

TRAINER'S NOTES

ABORTION, POST ABORTION COUNSELING

Abortion is the termination of a pregnancy on or before twenty-four weeks of pregnancy or before the foetus reaches the age of viability. Abortion can occur on its own in which case it is referred to as spontaneous abortion/miscarriage or can be induced. Induced abortion is common phenomenon among adolescents and young adults all over the world. Unsafe abortion is induced abortion carried out to terminate an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal standards or both. It is estimated that about 40% of maternal deaths are from abortion and its complications. There are about 610,000 unsafe abortions in Nigeria annually. In a study of 1000 female adolescents in Benin City, it was found that 68.8% of unintended pregnancies ended in induced abortion. In another study in Ilorin, 74% of the 264 women who presented with complications from induced abortion were adolescents.

The complications of abortion are multiple especially when it is unsafe. Once the process of abortion has started, it is important that safety of the women be considered the top most priority to prevent death or its complications. Avoiding pregnancy through appropriate counseling and refraining from unplanned sexual relations can prevent abortion.

TYPES OF ABORTION

Abortion can be broadly divided into two viz. spontaneous and induced abortions. Spontaneous abortion can be complete or incomplete. While the induced one can be legal or illegal, safe or

unsafe.

Spontaneous Abortion/Miscarriage

Spontaneous abortion commonly referred to as miscarriage occurs when pregnancy ends before the baby has any chance of survival. Most spontaneous abortion occur in the first 12 weeks of pregnancy, it may occur if a women has a serious febrile illness such as malaria, has a severe fall, or if the pregnancy is ectopic.

Complete Abortion

Abortion is described as complete when all the tissues of the developing embryo or foetus and the placenta have passed out through the vagina. When abortion is complete, the bleeding will stop after a few days.

Incomplete abortion

Abortion is incomplete when part of the products of pregnancy remains inside the uterus.

The dangers of Incomplete Abortion include:

- Severe bleeding
- Infection
- Infertility
- Death

Induced abortion

Is the deliberate termination of pregnancy for various reasons such as threat to the life of the pregnant women or for social reasons. Other reasons for induced abortion include ill health and foetal abnormality.

Legal abortion

This can be performed if the life of the woman will be jeopardized by the pregnancy.

Unsafe Abortions

This usually occurs where abortion is illegal. In some cases, women or adolescents may try to end their pregnancies by themselves or with the assistance of untrained personal. Some of the traditional methods used in unsafe abortion include inserting things into the vagina, swallowing special concoctions, taking very high doses of quinine, forcefully massaging the abdomen and washing out the vagina with harsh chemicals such as bleach.

Small Group Discussion

- Divide participants into groups of three (3).
- Ask them to discuss in 10 minutes the factors that are responsible for abortion in their communities.
- After 10 minutes ask the participants to reconvene, and each group to present to the larger group their discussion findings.
- Clarify and add any missing point.

TRAINER'S NOTES

FACTORS RESPONSIBLE FOR ABORTION

There are many reasons why women will want to have an abortion. Some of the reasons are:

- Shame and stigmatization associated with adolescent pregnancy
- The desire to continue school/education
- Pregnancy as a result of rape or incest
- Pregnancy that endangers the health of the woman
- Pressure from the partner responsible for the pregnancy
- Undesired pregnancy

SIGNS AND SYMPTOMS OF UNSAFE INDUCED ABORTION

- Fever or chills,
- Pain in the abdomen, cramping from the vagina
- Severe bleeding
- Foul smelling discharge from vagina

COMPLICATIONS OF INDUCED ABORTION

- Perforated uterus
- Injection
- Blocked tubes/infertility
- Death

MANAGEMENT OF COMPLICATIONS

In the case of induced abortion, the client can have an incomplete abortion, which could result in infection, bleeding and physical trauma. The woman will need medical care for emergency treatment of these complications. The counselor may refer such cases to appropriate places or health institution if not competent to manage such cases.

SUMMARY

Unsafe abortion can cause untold damage to health of the adolescent girl. However, information on pregnancy prevention can reduce need for abortion.

POST ABORTION COUNSELING AND POST ABORTION CONTRACEPTION

Post abortion care consists of emergency health care services (treatment of complications), family planning counseling and referral services given to a woman or an adolescent after an induced or spontaneous abortion. This has become a very important reproductive health issue given the present situation where abortion contributes highly to maternal mortality and morbidity. Many women suffer short or long term illness as a result of unsafe abortion or abortion complications, hence the need for post abortion care. This part of the session will treat their clients and refer appropriately for the treatment of complications.

Brainstorming

- Ask participants to mention the consequences of induced abortion.
- Record responses on a flipchart
- Display **slide** with consequences of induced abortion

CONSEQUENCES OF INDUCED ABORTION

- Ridicule by others
- Guilt
- Depression
- Disruption of normal school if complications occur
- Long term effect of secondary infertility

POST ABORTION COUNSELING

This is to help clarify feelings and thinking. The counselor can help the woman to get over the feeling of shame and guilt and /or depression. During counseling, education is given to the woman to help minimize the emotional and physical effects of abortion. The counseling session is also an opportunity to discuss pregnancy prevention or delay with the woman.

Counseling Process: - good counseling focuses on the individual woman's needs and situation, and good counselor listens to the woman's questions and concerns. Counseling must be based on trust and respect between the client and the counselor.

A woman receiving treatment for incomplete abortion needs to understand the following before she is discharged:

- The risk of repeating pregnancy is high (ovulation may occur as early as two weeks)
- There are a variety of safe contraceptive methods that can be used to avoid pregnancy.
- Where and how to get family planning methods.

The counselor will use this opportunity to provide information of family planning options available to forestall future occurrences; the counselor can encourage the client to commence a method.

POST ABORTION CONTRACEPTIVES

A woman's fertility generally returns within 2 weeks after an incomplete abortion in first trimester. Unfortunately, many women are not aware of this because it differs from postpartum period where the return of fertility is delayed. Because of the subsequent risk of repeated pregnancy, use of post abortion contraceptive should be initiated as soon as possible.

In general, all modern methods can be used immediately after post abortion treatment provided:

- There are no severe complications requiring further treatment,
- The client receives adequate counseling and
- The provider screens for any precautions for using particular method

As with all family planning counseling, the client will need to know:

- Advantages and disadvantages
- Side effects and risks
- How to use selected method(s) correctly

- When and where to obtain supply and re-supply
- Method reversibility
- How to stop using the method or switch to another method
- Counseling women about methods of post abortion contraception must include assessment of their risk for contracting STIs.

PREVENTION OF UNSAFE ABORTION

- Encourage abstinence
- Encourage use of contraception
- For sexually active adolescents stress the need for dual protection to prevent STIs/HIV/AIDS and pregnancy.

SUMMARY

The main objective of post abortion contraceptive counseling is to provide support to the woman (and in many cases her partner) so that she can decide whether to use contraceptive methods and if so, which. While counseling, the provider should ensure that the woman has all the information necessary to make an appropriate choice based on her individual circumstances.

Day 3 - SESSION 10

TOPIC: *IPC/C Skills: Listening, Questioning, and Paraphrasing*

TIME: Three Hours

OVERALL GOAL: Gain an appreciation for the communication micro-skills of listening, questioning and paraphrasing.

OBJECTIVES: By the end of this session, participants will have:

1. Listed and demonstrated three effective listening behaviors
2. Used different types of questions to encourage dialogue
3. Described the importance of reflecting and summarizing a client's feelings in an IPC/C interaction
4. Demonstrated their ability using three communication micro-skills.

BEFORE YOU BEGIN: You will need two participants to do role plays.

Please find volunteers and prepare them before the start of the session.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction	15 min	Discussion	
2. Listening Skills	30 min	Groups exercise Plenary process	Flip chart, Markers
3. Using Questions Effectively	30 min	Brainstorming Group exercise	Flip chart, Markers
4. Reflecting, Paraphrasing, Summarizing	30 min	Role play Discussion	
5. Practice	60 min.	Simulation in Small Groups	
6. Summary and Closure	15 min.	Exercise	

OVERVIEW: In this session, participants will review and practice the micro-skills of listening, questioning and paraphrasing through discussion and small group/triad practices. Emphasis should be on creating a safe environment for participants to make mistakes and learn as they develop the skills.

1. INTRODUCTION

Review the session objectives with participants and clarify as necessary.

Discussion/Reflection

Remind participants that the counseling process involves exchanging information and showing clients that you care about them. Both aspects of facts and emotions are included in the counseling process. Therefore, how you talk and how you listen is just as important as what you say.

Ask participants to remember a time when they were helped by talking with someone;

Ask them, silently, to recall how they felt about receiving help;

Ask them to reflect on what the person did that seemed to work well;

Ask for volunteers to share their thoughts on the above.

Make the point that what worked well for them would probably work for others as well. Remember that while we are service providers, we are also clients. What we like when we visit a service provider is probably similar to what other people like when they visit a service provider.

2. LISTENING SKILLS

Begin with clarifying the following points: Each interaction in a counseling meeting is a special mix of two world views plus an added dimension that exists as a result of the two people talking with each other. These three aspects are:

- 1. The Provider:** Personal cultural orientation including values and assumptions, his/her current personal issues, and his/her counseling skills and behaviors.

2. The Client: Personal cultural orientation including values and assumptions, his/her current personal issues, and his/her health issue which he or she must present to the provider.

3. The Interaction: The unique mix of both the counselor's and client's worlds in one moment in time.

Use **slide** to explain 3 areas of client-provider interaction.

TRAINER'S NOTES

It is essential in good counseling that we remember each person--the provider and the client—is a person first and foremost. Each may be a mother and/or a daughter, enjoy different activities, be experts at some things, and be inexperienced in others. It is important to understand the interaction that happens in the counseling setting is one small part of each person's life. It is where these two lives intersect. *Therefore, respect and interest in learning about each other is key to successfully working together towards a common goal.*

Listening Exercise

Introduce the role-play by explaining that the following exercises will sharpen and strengthen listening skills.

Divide the participants into pairs. One starts talking about contraceptives and youth while the other participant just listens without talking.

After two minutes, they change roles and one starts talking while the other listens without talking. Stop the exercise after two minutes.

Ask for volunteers to explain how they felt during the exercise.

Ask for some examples of how they knew that their partners were really listening to what they were saying.

Discussion

Ask participants what are some of the skills counselors need to exercise to be good active listeners? Write the responses on a flipchart.

Display a **slide** with possible responses - Ask participants if they remember the acronym ROLES:

Possible responses:

Some Non Verbal:

- ❖ Be attentive
- ❖ Concentrate on the client, look at them
- ❖ Don't interrupt

- ❖ Nod, smile, lean forward

Some Verbal:

- ❖ Make some sounds: ah..... Mmmmmm.
- ❖ Ask questions for clarification
- ❖ Reflect feelings and content
- ❖ Summarize the information

Remember: Steps for good VERBAL skills that support the GATHER process (**CLEAR**)

- Clarify their needs
- Listen carefully to what they have to say and address concerns they may have
- Encourage them to confide in you, praise her/him and try to accept him/her as they are
- Acknowledge how your client feels
- Reflect and Repeat – ask them to repeat instructions to reinforce understanding

TRAINER'S NOTES

Listening is a skill that requires constant practice. It includes both verbal and non verbal responses. The verbal ones include asking questions to clarify the situation, reflecting feelings and summarizing the main points. It helps confirm to the client that she/he is heard and understood. It helps the listener be sure she/he correctly understands the speaker. Often, one is able to point out issues or emotions of which a client may not be aware, particularly when a feeling is communicated non-verbally. Information such as this may in turn aid the decision-making process.

3. USING QUESTIONS EFFECTIVELY

Brainstorming

Ask participants to give examples of the different types of questions they normally use in a counseling situation. Write them on a flipchart. Ask them to identify the different types of questions from the list.

There are many possible responses; you are trying to get them to identify the following **four types (show slide)**: open-ended, closed-ended, probing and leading.

Ask for several examples of each type, and gently correct or re-categorize as necessary.

Ask them what we can learn through questions.

Ask for the reasons why they use the various types of questions.

What type of information are you trying to get from each type of question?

TYPE	EXAMPLE
Closed ended: Medical history	"When was your last menstrual period?"

Open ended: To learn about clients' feelings, beliefs, knowledge	"What have you heard about sexually transmitted infections?"
Probing: Follow-up in response to statement by client	"Can you tell me more about why you think condoms make a man impotent?"
Leading: NOT APPROPRIATE	"Don't you think you should try the IUD?"

Ask them in what circumstances, if any, the type of question would be appropriate in counseling? (See Trainer's Notes below)

Point out that **tone of voice is important** in asking probing questions in a non-judgmental way. Providers should use a tone of voice that expresses interest and concern.

Example: Ask the same question with different tones of voice: You have more than one sexual partner now?

Use **slide** to discuss the possible uses of different types of questions and refer participants to the table in their manual.

TRAINER'S NOTES

Ask Participants:

What are the goals of questioning and listening?

Possible responses:

- ❖ Start the dialogue
- ❖ Encourage the client to talk
- ❖ Communicate your interest to the other person
- ❖ Increase your awareness of the other person's feelings
- ❖ Bring out specific information
- ❖ Give a degree of control to the client

What we can learn through questions?

- ❖ **The general situation--** "What did you want to talk about?"
- ❖ **The facts--** "What happened?"
- ❖ **Feelings--** "How did you feel?"
- ❖ **Reasons--** "Why did you do that?"
- ❖ **Specifics--** "Could you give me an example?"

Closed-ended: Close-ended questions do not invite elaboration but a specific response. They

result in yes, no, or 1-2 word answers. They are useful in gathering factual information but not creating a comfortable environment in which true communication and decision making can occur. By using a series of closed questions, the clinic provider CONTROLS the interview. The client will only reveal information on the specific question asked. They are useful in collecting medical history, but should be only a starting point and should be followed by open-ended and probing questions.

Open-ended: How or what questions allow the client to describe and reveal information. The client can take the lead by choosing how and where the answer will go. It helps the provider get more information about the client.

Probing: Probing questions take a specific point, feeling, or issue and focus in-depth on it. This is useful when clients reveal a point in-passing. Probing is good when talking about sensitive topics which may be difficult for clients to reveal on their own.

Leading: Leading questions are rarely appropriate because they act as "door closers" and discourage the client from saying what she/he really feels. The provider risks making the client feel she/he must do what the provider says, even if it isn't what the client wants to do.

4. REFLECTING, PARAPHRASING, SUMMARIZING

Ask the participants to divide into pairs and discuss how they can make sure that they understand what the client is saying and feeling. Ask for volunteers to share their ideas. Write their ideas on a flipchart. If possible, group them into reflecting, paraphrasing and summarizing on the paper. Be sure they have reference to *feelings* and *content/knowledge*.

Role Play

Tell participants they will observe two different clients. They will write down each client's feelings and knowledge/understanding of the topic.

Make the arrangements with volunteers before the session starts.

SCENARIO 1:

Ask participants to observe closely the following client. Describe the scene, Ibrahim is a 21 year old man who is returning to the service provider, expressing the following concerns and complaints, (client could sound angry, agitated, or anxious):

Prepare a volunteer acting as Ibrahim:

*I do not like to use a condom. What can I do?????
But I am also scared of getting sexually transmitted infections
including the virus that causes AIDS. I am not happy with the situation I am*

facing.

Ask the participants to write down the client's expressed feelings (just the feeling words).

(**Note:** the only feelings explicit in the client's statement are scared, and not happy. The unexpressed, implicit feelings could be anger, fear, anxiety, dissatisfaction, confusion, etc.)

Ask them to decide what this man's main message is. Ask them to write down the content.

Ask for volunteers to share what they wrote about the Ibrahim's feelings and his message (content). See if others interpreted the same feelings and content.

SCENARIO 2:

Describe the scene: Talatu is a 16-year-old and sexually active. She is in the hospital with severe lower abdominal pain, foul vaginal discharge and fever.

Prepared volunteer acting as Talatu (she appears dull, talks in a monotone, very depressed, but gets tearful, upset):

I had a problem and I had to solve it. I've been here for two weeks and I'm very sick. My family has found out why I'm here and they are really angry with me.

Effective providers listen for "icebergs," i.e. cues from the client that need exploring deeper by the provider. They also know that through reflecting, paraphrasing and summarizing, they can learn more, clarify what they have heard, and feel confident that they understand the client.

TRAINER'S NOTES

Reflecting:

Clients must first believe that the provider hears and understands their feelings and individual needs and concerns before they are ready and willing to deal with a situation, listen to options, and make an informed and appropriate decision.

Accurate reflection and acknowledgment of *feelings* are necessary and critical to the counseling process. Reflecting phrases such as "you seem sad today" or "you sound very happy when talking about your children, but otherwise angry. Is this true?"

Emotions form the base of much of life experience. **Noting key feelings and helping the client clarify them can be one of the most powerful, helpful things a counselor can do.**

By observing and listening, providers imagine how a client feels. Then they tell the client what they think those emotions are. For example, when a client sounds and acts confused, the

provider can point this out by saying, “you seem confused.” This serves three purposes:

- 1) It makes the client think about how he or she feels and why;
- 2) The provider finds out whether or not the client is confused; and
- 3) If there is confusion, the client and provider can clear it up through discussion.

Paraphrasing:

Paraphrasing or reflecting *content* feeds back to the client the essence of what has just been said by shortening and clarifying client comments. Paraphrasing is not parroting; it is using your own words plus the important main words of the client to check accurate understanding of what the client has said.

Paraphrasing involves:

- 1) A *sentence stem* such as: you appear to be saying... or what I hear you saying is...
- 2) *Key descriptors* and concepts the client used to describe the situation or person. Use the client’s own words for the most important things.
- 3) *The essence* of what the client has said in summarized form.
- 4) A *check for accuracy*. Am I hearing you correctly?

Example:

Client: I don’t know what the matter is. I just don’t feel well today.

Provider: You’re feeling ill and you’re not sure why, is that right?

Paraphrasing is concerned with interpreting back to the client the essence of what has been said.

Reflecting relays back client emotions and key feelings the interviewer has observed.

When you reflect feelings, you can add to the paraphrase those affective or emotional words that tune into the person’s emotional experience.

Summarizing:

Summarizing is similar to paraphrasing except that a longer time period and more information are involved. Summarizing may be used to begin or end an interview, to transition to a new topic, or to provide clarity in lengthy and complex client issues or statements. It recaps what has been said.

Example: “At our last meeting we decided that each of us will carry out ten individual interviews with health care workers in the field to try to come up with a way to improve our system of supervision and support. Let us go around the group and discuss our findings.”

Example:

Client: “*I am terribly concerned over my wife. She has this feeling she has to get out of the house and see the world and get a job. I am the breadwinner, and I imagine I have a good income. The children view Sara as a perfect mother and I do too. But last night, we really saw*

the problem differently and had a terrible argument.”

Provider: *“Let me see if I can visualize the situation. You are concerned over your wife who wants to work even though you have a good income, and it resulted in a terrible argument. Is that how you see it?”*

At this point, ask participants if they have any questions about reflecting, paraphrasing and/or summarizing. Once questions have been answered, move onto the practice.

5. PRACTICE

Put up the **slide** describing the three skills of reflecting, paraphrasing, and summarizing on the screen. Explain to participants that they are going to now practice the specific counseling skills of questioning, reflecting, paraphrasing, and summarizing.

Divide the participants into new groups of 3 (different from previous groups of 3).

Explain that they will each play a service provider, a client, and observer. The observer will use the GATHER checklist – sections G and A to give feedback to the two after each round, pointing out how the skills were used.

Handout the role-play scenarios of this session to participants.

Allow participants 15 minutes (5 minutes each) to practice. They can choose any of the scenarios described.

When finished, ask everyone to reconvene. Ask for a few volunteers to describe what they experienced. Summarize the role-play, highlighting what strengths have been observed in the specific skills and what limitations.

6. CONCLUSION

Application

- Highlight the major lessons and points in the session. Invite participants to share their reactions and thoughts.
- Ask participants what new ideas they have learned or perhaps lessons they have remembered as a result of the session.
- Ask what behaviors they think will be easy to put into practice and what do they think will be difficult.

Summary

Do this first so that when each participant is finished with their Skills Review

they are free to go.

- Review the objectives of the session with the group.
- Link with the next session where you will look in more detail at the complete GATHER approach.

Evaluation

As a check on the skills training thus far, ask the participants to complete the **Counseling Skills Review Handout**. Tell participants you will collect these from them the next morning to review their responses. The trainer should **reassure** the participants that this is **not a test** but a check on their learning thus far and to help the trainer plan the rest of the training.

TYPES OF QUESTIONS

Close-Ended Questions	Open-Ended Questions	Probing Questions	Leading Questions
<p>When to use: Begin with closed-Ended question (for example, a question used in taking a medical history)</p>	Continue with an open-ended question.	Then use a probing question in response to a reply, as a request for further information. NOTE: Out of context, probing questions may sound leading.	Avoid using leading questions
<p>Requires: Brief and exact reply; often elicits yes or no response.</p>	Longer reply; demands thought, allows for explanation of feelings and concerns.	Explanation of an earlier statement.	Leads respondents to answer the question in a particular way or tells them about something that they might not otherwise have thought of.
<p>Examples: How many children do you have? Are you married?</p>	<p>What have you heard about abortion?</p> <p>What are the concerns of young people today?</p>	<p>Why do you think that oral contraceptives are difficult to use?</p> <p>What has made you believe your daughter is sexually active?</p>	<p>Have you heard that clandestine abortion is dangerous?</p> <p>Did you hear that the injectable stops the menses?</p> <p>Don't you prefer this method?</p>

SITUATIONS FOR ROLE PLAY

1. Maryam has come to the clinic for the first time. She is sitting on her own in a corner, far from the other clients and she looks unhappy. All the other clients in the waiting area are busy talking and laughing with each other. As you have been passing up and down, you noticed Maryam sitting in the corner. After some time, Maryam comes to your room.

2. Zara has come to the clinic for the second time in a week because she is bleeding from her private part (vagina). She is looking anxious and would not talk to anyone. She is waiting to be attended to.

3. A young mother has a three-month-old infant boy. This is her first child and her first visit to the clinic. She wants to postpone her next pregnancy. Her sister uses Oral Contraceptives and likes the method. She says she wants to use OC.

4. Amina is 16 years old. She is married with one child who is 8 months old. She had a forceps delivery and wishes to spend another year before having another baby.

5. You are Talatu, an 18 year old and you have two boyfriends. Both do not want to use condoms and you are not ready to lose either of the boyfriends. Recently, you have had a smelly vaginal discharge. You come to the FP clinic because you want to use pills that will keep you from getting pregnant.

6. Adama is a 16 year old SS 2 student who has come to your clinic for an advice what to do. She has had sex 3 times in the last two months, she said her menses is delayed; she is afraid she might be pregnant.

COUNSELING SKILLS REVIEW

NAME: _____

Generating written questions, encouragers, paraphrasing/summarizing and reflecting feeling

A young Nigerian woman is saying:

“I’m really feeling sad right now. My boyfriend just told me that he doesn’t want to see me anymore. Now I really don’t know what to do. I’ve tried everything. If only my mother had not been so strict with me. She was unfair to give me such an early curfew. She really makes me mad! But maybe I should have been nicer to my boyfriend. I just feel so confused about what to do next.”

Your response would be:

Write an open-ended question

Write an encourager

Write a paraphrase (reflect content)

Write a reflection of feeling

Day 3 - SESSION 11

TOPIC: *Effective Use of IEC Materials*

TIME: Three hours

OVERALL GOAL: To teach the service providers how to effectively use IEC materials during IPC/C sessions with clients.

OBJECTIVES: By the end of this session, participants will have:

1. Identified four reasons why it is important to use IEC materials in counseling.
2. Described the components of an effective environment for IPC.
3. Listed four advantages and four uses of different kinds of IEC materials.
4. Practiced effective information-giving, particularly counteracting rumors.
5. Demonstrated effective use of IEC materials during counseling interactions.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction	10 min	Drawing exercise	PowerPoint
2. Barriers to using IEC materials	15 min	Individual Exercise, group discussion	PowerPoint Flipchart, Markers
3. IEC Materials Advantages, Limitations and Uses	35 min	Discussions Demonstrations	Display materials available for use
4. Practice using IEC materials appropriately	70 min	Small group exercise	Materials available for use and 1 photocopy of the role-plays for each station
5. Counteracting Rumors	40 min	Group discussion	Flip chart, Markers
6. Conclusion	10 min		

OVERVIEW:

Participants will learn how to use each IEC material appropriately and practice their use in counseling role-plays. Again, emphasis should be on creating a safe environment for participants to make mistakes and learn as they develop the skills.

1. INTRODUCTION

Review the objectives with all providers and ask if any points need clarification. Tell participants that we want to begin this session with a short drawing exercise.

Drawing Exercise

Request participants to take out their pencil/pen and paper for an exercise. Explain that you will ask them to draw an animal based on a verbal description. Say you will read the description only twice, and then give them three minutes to draw the animal. Tell them that drawing skills are not important. Read the description:

"The body is large. The limbs are short and large, armed with strong, blunt toes. There is a small tail. The head is rather flat and set on a short, thick neck. The ears are very big and long. Its long nose ends in a circle in which nostrils open. The mouth is small with a very long thick tongue."

At the end of three minutes or so, ask the participants to hold up their drawings. Tell the group that you had a very clear idea what you wanted them to draw and gave very specific verbal instructions. Then show the **slide** of the elephant. Read the description and point to each part of the picture on the overhead.

Ask participants: Was it easy or difficult to draw the animal based on my description? Why/Why not? What lessons can be drawn from this exercise? (See Trainer's Notes below)

Possible responses:

- ❖ A picture is worth a thousand words.
- ❖ Pictures can prevent misunderstandings.

TRAINER'S NOTES

Points to emphasize during the discussion of the elephant:

- 1) The listener assumed she/he understand what the speaker said.
- 2) The speaker assumed she/he was giving clear instructions.
- 3) The words were not enough to help understand what was being communicated.

Emphasize that visual aids are not a substitute for skillful face-to-face counseling. They are tools to improve the quality of counseling, the clinic provider's satisfaction of a job well done, and the

satisfaction of clients whose Reproductive Health needs are being met.

Explain that people understand you better if you use IEC materials when describing or explaining. They'll also remember the content longer. This is useful not only in counseling, but also in training.

It is often easy to assume that those with whom we interact understand our words and therefore our meaning. However, everyone has experienced a situation where a spouse, child or parent has misunderstood a message we sent because we

- 1) Assumed they understood what we said.
- 2) Assumed we were giving clear instructions.
- 3) Assumed the words were enough to help understand what was being communicated.

Information becomes distorted and details forgotten during a typical course of conversation. This results in rumors and misconceptions. An important job of service providers is to give correct information, to educate on reproductive health methods and procedures. They will often encounter rumors and misinformation during the course of their work. It is not enough to simply tell clients what is correct or not correct. We must also explain and show why the information is correct, in terms they can easily understand. We have to do this persuasively, politely and with respect for the client's ideas and perspective.

IEC materials help the service provider communicate more effectively with clients and ensure a greater understanding of the information by the client.

2. BARRIERS TO USING IEC MATERIALS

Explain that we first want to understand our participants, the service providers better.

Write this question on a flipchart or transparency: *Why don't providers use IEC materials?*

Ask participants to identify reasons why providers might not use all the IEC materials during counseling. Record the answers on the flipchart.

Why don't providers use IEC materials?

Possible responses:

- ❖ They are not available (stored away or not at the service site)
- ❖ Don't know the importance of using
- ❖ Lacking knowledge on how to use them
- ❖ Language barrier (if in the local language)
- ❖ They need more time to use
- ❖ Negligence
- ❖ Assume client already knows so no need to see them
- ❖ Not told by supervisor to use them
- ❖ Using them takes too much time

Using this list, identify ways to overcome the problem of not using IEC materials in counseling situations. Brainstorm as a group and write responses on a flip chart.

Discussion

Why Use IEC Materials When Counseling?

Using IEC materials effectively is a critical skill in effective counseling.

- ❖ Attracts the client's attention
- ❖ Triggers discussion
- ❖ Helps client bring up questions
- ❖ Makes something very small (e.g., ovum or sperms) big enough to be visible
- ❖ Can be used to compare similarities and differences (e.g., types of IUD)
- ❖ Shows steps in doing something (e.g., insertion of IUD)
- ❖ Shows changes (e.g., growth of a fetus from conception to delivery)
- ❖ Makes complex ideas easier to understand
- ❖ Can show things that people can not see in real life (e.g., position of IUD in the uterus)
- ❖ Can help when discussing a sensitive topic or a complicated topic like child survival
- ❖ Clients can take print materials home as reminders
- ❖ Clients can share print materials with husbands and friends
- ❖ Increases client's level of understanding the information provided

3. TYPES OF IEC MATERIALS: ADVANTAGES, LIMITATIONS AND USES

Before the session begins, prepare a table at the front of the room displaying a few IEC materials available to service providers. Try to get different kinds of materials such as posters, models, flipchart, booklets, radio dramas, pamphlets from different areas of RH, cue cards, samples, etc. Facilitator will now talk specifically about IEC materials.

Ask participants the following question:

What types of IEC materials are available to clinic providers (YOU!) for counseling now?

List the different materials that the providers mention and add any available items that they don't already know about.

Small Group Work

Break the group into smaller groups.

Give each small group one IEC material from the display table. The number of groups will depend on the number IEC materials available. If there are more than enough, then groups of 3-4 will do.

Ask each group to focus on two different audiences: *the client* and *the provider*.

Ask each group to think about the list of advantages they came up with earlier in the session and brainstorm a list of the advantages, the limitations and the appropriate use for the material for each audience.

Large Group Processing

Ask each group to present their results. Ask others to add if they think of something missing. At the end, you should have a complete list of advantages, limitations and appropriate uses of IEC materials for both the client and the provider.

Show **the slides for clients and providers (this is also a worksheet in their manual)** for participants to review. Tell them that their ideas will be added to this list. They should continue thinking about the materials and if any more ideas come up, they too, can be added to the list.

TRAINER'S NOTES

Advantages of Using IEC Materials

For Provider:

- ❖ Attract the client's attention.
- ❖ Trigger discussion and help bring up questions from clients.
- ❖ Make something small big enough to be visible (i.e. eggs, types of IUD).
- ❖ Compare similarities and differences (i.e. types of IUD).
- ❖ Show steps in doing something (i.e. insertion of IUD).
- ❖ Show changes (i.e. growth of a fetus from conception to delivery).
- ❖ Make complex ideas easy to understand.
- ❖ Show something that cannot be seen in real life (i.e. position of IUD in the uterus).
- ❖ Help when discussing a sensitive topic such as FP or HIV/AIDS.
- ❖ Clients can take print materials home as reminders.
- ❖ Clients can share print materials with spouse and friends.

For Client:

- ❖ Help to make the best decision for their health needs.
- ❖ Help client to understand what to expect from their decision.
- ❖ Help to remember the accurate usage of contraceptive method, for example, or key information on nutrition, planning for safe birth or other behaviors that have specific instructions to follow.
- ❖ Help to understand what is happening inside the body (e.g. during pregnancy, during unsafe delivery, the way contraceptives work etc.)
- ❖ Can be taken home to be a reminder.

- ❖ Can be shown/ distributed to partner or friends.

Limitations of Using IEC Materials

For Provider

- ❖ No opportunity for discussion unless service provider reviews with clients.
- ❖ Can be expensive to produce.
- ❖ If not well made, pages may tear when flipping over.

For the Client

- ❖ Less effective with people who do not read.
- ❖ Can be easily lost and sometimes are thrown out without reading.
- ❖ The message may not be understood by audience; may need explanation.
- ❖ Not good for large groups.
- ❖ Audience may not remember everything if there is too much information.

4. USE OF IEC MATERIALS

Discussion

Tell the participants that we will now spend some time reviewing techniques that can help them use visual aids more effectively. One by one, you will discuss with the group and brainstorm how best to use the material in a counseling situation.

The discussion should focus on:

- ❖ identifying how to physically hold the material
- ❖ identifying when to give the material to the client
- ❖ letting the client touch or hold the material
- ❖ how to stand or sit in relation to the material and the client
- ❖ what specific points to go over with the client
- ❖ what to leave for the client to review on his/her own time

Additional information can be found in their manuals “**How to use IEC materials**”.

Begin with a flipchart.

Demonstrate inappropriate use of a flip chart and ask the group what you did well and poorly. Ask someone to demonstrate proper use of flip chart.

Ask two volunteers to role-play in front of the class. One will play as a provider and another one will be a client. The provider will explain about a particular health condition using a visual aid (flip chart) for 1 minute. When it is done, ask the one who plays the client if she is clear about the information given? Ask other participants who watch the role play to give their comments.

Next, move to posters.

Ask how you might elicit discussion using a poster. (Show a sample poster). Ask participants to come up with three questions they might ask to initiate a discussion from a poster. Explain that the same techniques can be used to prompt discussion using other types of visual aids. Again, ask a volunteer to demonstrate using a poster.

Continue with the other materials, discussing, demonstrating and having volunteers try the appropriate use.

5. PRACTICE USING IEC MATERIALS

Small Group Practice

Tell the group that everyone is now going to actually practice using the IEC materials in a counseling situation.

Divide the participants into groups of three (different from previous groups of three). Prepare stations of materials. For example, Station 1 may be a poster, Station 2 may be a leaflet, Station 3 may be a model, etc.

The groups will rotate among each station. At each station, each participant will have an opportunity (three minutes) to practice using that material with the other two participants role-playing the client. Place a **photocopy of the suggested role-plays** at the end of this chapter by each station to provide a situation for using the IEC material. The clients should provide feedback to the provider.

Rotate until all groups have had a chance to practice on all the materials. You, the trainer, will need to visit each group to make sure they are on the right track.

Discussion

After sixty minutes or so, gather the groups together in a large group. Ask volunteers to comment on what happened during the practice, what lessons were learned about using IEC materials in counseling.

6. COUNTERACTING RUMORS

Explain that the important job of providers is to give correct information and to educate on methods and procedures. We often encounter rumors and misinformation in the course of our work. It is not enough, however to simply tell clients that what they have heard or what they believe is wrong. We must **explain or show why** the information they believe is incorrect **in terms they can easily understand**. We have to do this persuasively, politely and with respect

for the client's ideas and perspective. Remember, we do not want to make clients feel stupid because they heard and perhaps believe some incorrect information. We all have been in their shoes at one point in our lives!

Telephone Exercise

Tell the participants they are going to participate in an interesting and fun exercise on communication. Divide the group in half. Tell one half to stand in a line facing the center of the room. The other half should form a line facing the first group, but out of hearing distance. Tell them you are going to tell the first person in each line a story--only once! Then, that person will whisper it to the next person in line, who will whisper it to the next person, and so on.

Tell participants they may talk until it is their turn to listen to the story. Then they must listen. If the line is more than four people, have the person who is halfway down the line (the middle person) write down what he/she has heard after he/she passes along the story.

This is the story: *Nana is going to have a baby. She was planning to take pills but didn't have a chance to arrange an appointment before she became aware that she was pregnant.*

When the last person in each line has heard the story, have the last person repeat it out loud. Ask those who have written the story down to repeat what they heard. Then read the story you told them.

Ask the group:

- a) How did the story change?
- b) Why?
- c) How does this apply to the spread of rumors and misinformation?

Make the point that information becomes distorted and details are forgotten during a typical course of conversation in a community. This results in rumors and misconceptions.

Mention that it is human nature to add to or embellish the story we are telling in order to make it more interesting. This creates a special challenge for providers to correct rumors and misconceptions.

Discussion

Divide participants into groups of three. Ask each group to list some of the common rumors associated with birth spacing, abortion, early childbearing or other reproductive health issues. Ask groups to share their lists. Tell participants that many of the rumors they mentioned are very common in our society, so it is thus very important that health providers learn to counteract them and correct any misconceptions.

Ask participants to think about possible causes of these rumors. Record some suggestions on a flip chart

Possible answers:

- ❖ Inadequate or incorrect information on the provider's side.
- ❖ Inadequate or incorrect information on the client's side.
- ❖ Misinformation, either through intentional or accidental distortion of truth.
- ❖ Normal side effects that are not adequately explained by the service provider or IEC materials.
- ❖ Cultural and personal values that appear to conflict with the concept of family planning and other RH issues.

Ask participants to think about rumors and ways to counteract them. Lead a discussion on how to clarify rumors. (See Trainer's Notes below).

TRAINER'S NOTES

To counteract rumors effectively, providers need to:

- a) Understand the cause of the rumor
- b) Explain why the rumor is not true and
- c) Provide the accurate information.

In the case of misconceptions, the provider should give a correct picture of the situation. When possible, the provider should demonstrate (e.g., pull and stretch a condom to correct the rumor that condoms are not big/strong enough) or give specific examples using available IEC materials to counter the rumor.

A **rumor** is: Inaccurate or untrue information that is passed from one person to another and the original source is unknown.

Consider the sources, such as satisfied users and community leaders, who would be valuable in combating rumors and how providers can use their support.

- ❖ Enlist satisfied users as outreach workers, peer counselors.
- ❖ Obtain clergy's permission to use facilities to post information, hold performances or group talks, etc.

Return to the participants' lists of rumors and ask how they would counteract these.

- Rumors and misconceptions are often the result of trying to make sense out of incomplete or confusing information. People often try to "fill in" or interpret information according to their own knowledge or values.
- Once the underlying reasons for a belief are understood, it is easier to find appropriate responses to counter incorrect information.

- A believable source with similar values and backgrounds can help counter rumors. Testimonials are a great tool in counteracting rumors.

7. CONCLUSION

Ask the group to consider what new lesson they have learned from the session. Emphasize once again, the importance of using IEC materials in counseling and that practice will help participants feel more at ease with them. Encourage participants to come to the training room in the evening (if possible) to continue practicing, and let them know that there will be more time tomorrow for practice.

Application

- Highlight the major lessons and points in the session. Invite participants to share their reactions and thoughts.
- Ask participants what new ideas they have learned or perhaps lessons they have remembered as a result of the session.
- Ask what behaviors they think will be easy to put into practice and what do they think will be difficult.

Evaluation

Ask the participants again for some of the benefits and limitations of different forms of IEC materials.

Summary

- Review the objectives of the session with the group.
- Link with the next session where you will specifically continue practicing IPC/C skills i.e. putting it all together session.

ADVANTAGES OF USING IEC MATERIALS

For Provider:

1. Attract the client's attention.
2. Trigger discussion and help bring up questions from clients.
3. Make something small big enough to be visible (i.e. eggs, types of IUD).
4. Compare similarities and differences (i.e. types of IUD).
5. Show steps in doing something (i.e. insertion of IUD).
6. Show changes (i.e. growth of a fetus from conception to delivery).
7. Make complex ideas easy to understand.
8. Show something that cannot be seen in real life (i.e. position of a baby in the womb).
9. Help when discussing sensitive topics like birth spacing, post-abortion care, safe motherhood, and youth reproductive health.
10. Clients can take print materials home as reminders.
11. Clients can share print materials with spouse and friends.

For Client:

1. Help to make the best decision for their health needs.
2. Help client to understand what to expect from their decision.
3. Help to remember the accurate usage of contraceptive method, for example, or key information on nutrition, planning for safe birth or other behaviors that have specific instructions to follow.
4. Help to understand what is happening inside the body (during pregnancy, during unsafe delivery, the way contraceptives work)
5. Can be taken home to be a reminder.
6. Can be shown/ distributed to partner or friends.

LIMITATIONS IN USING IEC MATERIALS

1. No opportunity for discussion unless Clinic Provider reviews with clients.
2. Less effective with people who do not read.
3. Can be easily lost and sometimes are thrown out without reading.
4. Can be expensive to produce.
5. The message may not be understood by audience; may need explanation.
6. Cannot communicate many written messages.
7. Not good for large groups.
8. If not well made, pages may tear when flipping over.
9. Audience may not remember everything if there is too much information.

ADVANTAGES, LIMITATIONS AND USES OF IEC MATERIALS

TYPE OF IEC MATERIAL	ADVANTAGES	LIMITATIONS	USES
<p>Pamphlets Booklets Leaflets</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Can be given out to large numbers of people. <input type="checkbox"/> Clients can read at their own speed, as often as they want. <input type="checkbox"/> Clients can share them with their family and friends. <input type="checkbox"/> They are easily produced. 	<ul style="list-style-type: none"> <input type="checkbox"/> No opportunity for discussion unless Clinic Provider reviews with clients. <input type="checkbox"/> Less effective with people who don't read. <input type="checkbox"/> Paper is not strong, they are easily lost and sometimes are thrown out without reading. <input type="checkbox"/> Can be expensive. 	<ul style="list-style-type: none"> <input type="checkbox"/> For people who can read <input type="checkbox"/> To present words and pictures. <input type="checkbox"/> For detailed information/instruction. <input type="checkbox"/> To get information to a lot of people <input type="checkbox"/> To remind people what you have taught them.
<p>Posters (usually have one message – a slogan and a picture)</p> <p>Charts (usually have a lot of information)</p> <p>Photographs</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Can be made locally. <input type="checkbox"/> Can be used repeatedly. <input type="checkbox"/> Can carry easily. <input type="checkbox"/> Can show things that cannot be easily demonstrated on real objects. (e.g. sex organs) <input type="checkbox"/> Good for many topics. 	<ul style="list-style-type: none"> <input type="checkbox"/> The message may not be understood by audience; may need explanation. <input type="checkbox"/> Can be expensive because they are easily destroyed. <input type="checkbox"/> Making them requires time for pretesting. <input type="checkbox"/> Cannot communicate many written messages. 	<ul style="list-style-type: none"> <input type="checkbox"/> To reinforce message. <input type="checkbox"/> Small or large groups. <input type="checkbox"/> To be put in places where seen easily. <input type="checkbox"/> To promote and idea, event or service. <input type="checkbox"/> Can be used in counseling.

<p>Flipcharts Flipbooks</p> <p>(A collection of pictures arranged in order and fastened at top.)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Can be made locally <input type="checkbox"/> Can be made to suit needs of individual groups <input type="checkbox"/> Good for maintaining audience interest. <input type="checkbox"/> Can be used repeatedly. 	<ul style="list-style-type: none"> <input type="checkbox"/> Not good for large groups <input type="checkbox"/> If not well made, charts may tear when flipping over. <input type="checkbox"/> Audience may not remember everything if there are too many charts 	<ul style="list-style-type: none"> <input type="checkbox"/> For step-by step presentation (e.g. instructions, story) <input type="checkbox"/> For small groups or individuals.
<p>TYPE OF IEC MATERIAL</p>	<p>ADVANTAGES</p>	<p>LIMITATIONS</p>	<p>USES</p>
<p>Models</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Close to reality; will lead to better understanding <input type="checkbox"/> Can be made in a larger form for clearer viewing. <input type="checkbox"/> Allows persons to practice a task or skills <input type="checkbox"/> Allows use of all senses 	<ul style="list-style-type: none"> <input type="checkbox"/> May need skills and materials to make them. <input type="checkbox"/> Can be expensive. <input type="checkbox"/> Can't use with large groups. <input type="checkbox"/> Easily damaged. <p>Usually not as good for demonstration as real object or person.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Giving instructions, demonstration (e.g. preparing oral rehydration solution, how to use pill packets). <input type="checkbox"/> Good for one-to-one or small groups.

HOW TO USE IEC MATERIALS

HOW TO USE POSTERS

There are two kinds of posters:

1. Posters to motivate client
2. Posters to educate

1. Display motivational posters in places of high visibility around your health center, such as waiting rooms, counseling rooms and examination rooms. Think about *what* the poster is meant to do and *who* will see it. You also can use posters to stimulate discussion with your client.
2. Ask clients what they see and what it means to them. If correct, reinforce positively her understanding. If incorrect, correct the understanding in a polite and patient way.

HOW TO USE FLIP CHARTS

1. Position the flipchart so that everyone can see it.
2. Point to the pictures, not the text.
3. Face the client or audience (for group talks). Move around the room for groups with the flipchart if the whole group cannot see it at one time. Try to involve the group.
4. Ask the client(s) questions about the drawing to check for accurate understanding.
5. If the flipchart has text, use it as guide, but familiarize yourself with the content so that you are not dependent on the text.

HOW TO USE BOOKLETS

Booklets are designed to reinforce or support verbal messages of health workers. If used properly, they strengthen the messages you give to clients. The following are suggestions on how to use the booklets:

1. Go through each page of the booklet with the client. This will give you a chance to both show and tell about a health problem or practice and answer any questions the client has.
2. Point to the pictures, not to the text. This will help the client to remember what the illustrations represent.
3. Observe the client's reactions. If your client looks puzzled or worried, encourage him/her to ask questions or talk about any concerns. Discussion helps establish a good relationship and

builds trust between you and the client. A person who has confidence in his or her health worker will often transfer that confidence to the method or health practice selected.

4. Give the client the booklet. Suggest that he/ she share it with others, even if the client makes a decision not to use the method or health practice described.

HOW TO USE CUE CARD/INFORMATION CARDS

These **cue-cards** are designed for provider/ Counselor who are working in the clinic setting or those in the field. The cards are meant to assist provider to remember important information about contraceptive methods which will be conveyed to the client so that they can choose an appropriate, safe and effective methods. **Information cards** are designed to share with the client. They provide information in text and pictures in a concise, one-page format.

1. Help client to feel comfortable: Give a warm greeting. Sit together with them for a while before starting a counseling session. If they just hear about FP, give them information about reproduction.
2. Show “Information Card” to client: The best way to use information cards is to show it to client during counseling. When showing the card, involve the client as much as possible. People usually give more attention when given the opportunity to be actively involved and a part of a discussion. Try not to read the card. When you point to the card, you have to remember that the focus is still the client. Full eye-contact with client will be more effective in communication. Help them to come up with questions until they understand that they can ask whenever they want to. Let them hold the cards.
3. Let the client choose: Let client choose which method they want to know before you give your suggestion. This will help them to make decision.
4. Communicate slowly and clearly: At first, avoid technical terms which will not be understood by the client. Give time to go over all information on the card. You don't have to explain all contents of the card to the client, but make sure that they know about methods which might be appropriate and suitable for their condition. Make sure about their understanding. Go through the information more than one time if necessary.
5. Show examples of real contraceptive: While reading or showing the card also show the real contraceptive method, and let them keep it. This will help them remember better.
6. Help them choose a contraceptive method: Remember (and remind them) that this is their choice. When they ask for suggestions, think about the wish, choice and the medical history and physical examination of the client. If they are done, use questions written at the back of the card to help you and your client in deciding which method is appropriate for the client.
7. Go over information on how to use the method: Once the client has made her decision,

it is good to go over to how to use the method chosen. Ask client to repeat by giving explanation to you about all instructions. This is to make sure that she really understands. Give complements when she has a good understanding.

8. Talk about the possibility of side effects: Clearly explain to them about the differences between side effects and early symptoms. Act and think positively. Try not to make your clients over-worried without good reason.
9. Ask client to come back: Ask client to come back by deciding on the date. Tell them that they can come back earlier if they have questions. Show them that you really care.

ROLE PLAY INSTRUCTIONS: PRACTICING COUNSELLING WITH IEC MATERIALS

INSTRUCTIONS:

1. Read the four scenes.
2. Select a scene to role play.
3. Decide which role to play: The clinic provider, the client, the observer (there will be one or two observers depending on the scene chosen).
The observer's role is to act as a timer and also watch the use of IEC materials.
4. Begin the role play, focusing on the use of IEC materials rather than an entire counseling sequence.
5. Observer should stop the role play after giving adequate time for the "provider" to illustrate use of IEC materials.
6. Observer processes role play by asking the provider his/her opinion about his/her performance, then client, then observer gives feedback.
7. Group members change roles, select another scene and continue with #1 to #4 activities. Everyone should have the chance to role play the clinic provider role.

ROLE PLAY SCENARIOS

1. A couple from a nearby village comes to the clinic and mentions that they both decided that five children are all they want and can afford. One of their neighbors told the wife there are some injections that make you stop having children. Since the wife has a heart problem, the husband wants to know if he can have the injections. The couple goes to the health center to consult a health worker.
2. Tanko and Ladi have two children and would like to wait a while before having another one. Ladi has heard good things about the IUCD and was planning to try it. However, just a few days before her appointment for IUD insertion, she heard a rumor that someone from the next town became pregnant with the IUD in place and has given birth to a deformed baby. Ladi became scared and visited the health center with Tanko to ask the nurse about it.
3. Maryam is a 28-year-old mother of two children who is using the IUD. She has some complaints about it and would like to switch to another method. She has heard good things about the Pill from her co-workers but does not know much about it. She visits the counselor at the health center to find out more.
4. Fati has four children and is pregnant. She is thinking about having a tubal ligation right after delivery of her fifth baby. She and her husband visit the nurse at the health center to ask for advice about tubal ligation and to find out more about what it entails.



Day 3 - SESSION 12

TOPIC: Putting it all Together: IPC/C Skills and GATHER

TIME: Whatever is left in the day

OVERALL GOAL: To review the specific skills component of the entire GATHER framework

OBJECTIVES: By the end of this session, participants will have:

1. Reviewed the GATHER checklist with their practice sessions in mind
2. Had the opportunity to ask for any clarifications on the self-assessment checklist and/or specific counseling skills including the use of IEC materials.

Notes for the Facilitator:

This session is really to be applied at the discretion of the facilitator. At a minimum, review the entire self-assessment worksheet with the participants to make sure that each part of the GATHER process and its components are clear. Address any concerns and feel free to demonstrate skills where the participants feel weak. Remind them that they will have more opportunity to practice tomorrow.

INTRODUCTION

This session is aiming at pulling altogether what the participants have learned so far, through the use of GATHER self-assessment form.

However, before proceeding with the session, facilitator should find out whether each part of the GATHER process and its components are clear to the participants.

Small Group Practice

- Divide participants into group of three's (3's)
- In groups of three, each participant will take turns acting as a provider, a client and an observer.
- Each group should create an entirely new role play to practice with OR choose from the previous session's role plays which interest them.
- The observer uses the GATHER Checklist

After 3-4 minutes of role play, the observer should give feedback (1-2 minutes) to the provider on what happened positively and on what could be improved. Then the three group members should switch roles and repeat the exercise. After the second role play, switch roles and repeat a third time. At the end, each group member has played a provider and a client and has observed.

Facilitator can visit and guide each group during the practice.

When the practice is over, bring everyone back to the larger group and address any concern. Especially the skills where the participants feel weak.

SUMMARY

Summarize the experience gained from the individual exercises. Point out that a variety of IPC techniques must be used. The skill is in knowing when to use each one.



Day 4 - SESSION 13

TOPIC: *Summary of Day 3, SM technical overview*

TIME: Two hours

OVERALL GOAL: To provide technical information for the trainees on the field of Safe Motherhood services

OBJECTIVES: By the end of this session, participants will have:

1. Understood issues in safe motherhood
2. Known the major causes of maternal deaths
3. Understood the three delays (3D's) associated with maternal deaths
4. Known the key intervention areas in safe motherhood

Notes for the Facilitator:

The first session of each day is relatively flexible – the technical overview will probably not take more than one hour, though there should be time for discussion. Feel free to use this time to recap the previous day, clarify any questions that may have come up overnight, or redo/review any exercise from the previous day that was not adequately completed or understood.

The next session is a long one, and so it should be started as part of this session once the technical overview has been completed.

OVER VIEW OF SAFE MOTHERHOOD

Brainstorming

- Ask participants to mention the risks associated with pregnancy and the major causes of deaths among pregnant women in their localities.
- Record responses on a flipchart.
- Display **slide** with the risks associated with pregnancy.
- Clarify the points and correct any misconception

TRAINER'S NOTES

SAFE MOTHERHOOD

Nigeria has one of the most serious maternal mortality problems in the world. With only two percent of the world's population it contributes ten percent of its maternal deaths from childbirth. Surmounting this crisis is not simply a medical or technical issue. It is also a political challenges: ensuring that political, social and religious leaders at the federal, state and local levels make safe motherhood a policy priority an back this up with sustained attention and advocacy, and financial and technical resources commensurate with the severity of the crisis.

The risk of pregnancy and childbirth for adolescent girls

Pregnancy is risky for every woman, but it is especially risky for adolescent girls. The main problem for women under 20 is that the pelvis (the bones surrounding the birth canal) is still growing. Girls who become pregnant at a very early age often have difficult deliveries because the pelvis is too small, and the baby cannot pass through it. This is called **obstructed labor**.

If the baby cannot pass out of the body, it may be necessary to have an operation called a **caesarean**

section in order to remove the baby through a cut in the woman's abdomen. In rural areas, many women with obstructed labor are not able to reach a hospital in time. The baby may die inside the uterus, or the uterus may tear during a lengthy labor, and the woman may die of blood loss. This is one reason why many adolescent girls die in childbirth.

Pregnancy can happen if one sperm cell meets with an egg and fertilizes it inside the woman. If the egg is fertilized, it can attach itself to the lining of the uterus (womb). This is the beginning of pregnancy.

Signs of pregnancy:

- A missed menstrual period
- Tenderness (soreness) of the breast.
- Nausea (feeling as though you need to vomit).
- Fatigue (feeling very tired).
- Needing to urinate more often.

Pregnancy is especially risky for adolescent girls because their bodies have not fully matured. Adolescent girls are more likely to have serious health complications during pregnancy and delivery than older women. Therefore, it is especially important for an adolescent girl to get proper care during pregnancy. It is advisable to deliver in a hospital where they have the staff and equipment to manage complication.

Prolong labor

A lengthy labor can cause complications or unsafe motherhood. After many hours of labor, the baby's head can stretch or tear the vagina, causing a hole between the vagina and the bladder or between the vagina and the rectum. This hole is called a fistula. Because of the hole the girl or woman will not be able to hold her urine or faeces. Urine or faeces will constantly leak out through the hole, and down her legs. She will smell bad and may get sores from the constant irritation of urine on her skin. These groups of women are rejected by their families and the community. The only solution is an operation performed by a specialist to repair the hole.

Other complications of labor are anemia, high blood pressure resulting in eclampsia (dangerous fits during pregnancy, which leads to many complications and death).

- More than 150 million women become pregnant in developing countries each year, and estimated 650,000 of them die of pregnancy-related causes. This death rate is roughly equivalent to 4 jumbo jet crashing every day- a terrible loss
- Every minute in the world a woman dies as a consequence of pregnancy or delivery, most of them in developing countries in Africa and Asia.
- **Five major causes of maternal deaths are: hemorrhage, infection, unsafe abortion, obstructed labor, hypertensive disease of pregnancy (eclampsia).**

The 3 delays associated with maternal deaths are;

- *Phase 1 delay* – Delay in seeking care
- *Phase 2 delay* – Delay in reaching the health facility
- *Phase 3 delay* – Delay within the health facility

Caring for yourself during pregnancy

Because pregnancy is such a big strain on your body and a big risk for your health, it is important to get proper care.

- Start going for antenatal care as soon as you know that you are pregnant. Don't wait until you are "showing" i.e. when the pregnancy becomes advanced. The purpose of antenatal care is to ensure that you and the baby are in good health. Antenatal care is also important for recognizing any problem and treating them promptly.
- Be organized. Follow a schedule of regular visits for antenatal care. Go as often as the midwife tells you.
- Sleep under a mosquito net, and protect yourself from malaria.
- Get plenty of rest
- Think about what you eat, and make sure that it is nutritious. Eat "grow foods" such as beans and eggs. Eat plenty of fresh fruits and greens. You also need minerals such as calcium. Calcium is found in milk but a less expensive source is small fish with bones still in them.
- Take the iron supplement provided by the hospital or clinic. Your body needs a lot of iron to stay strong and healthy during pregnancy.

Key intervention areas in Safe motherhood

- Life saving skills
- Free maternal services
- Policies on RH
- Budget for RH

Day 4 - SESSION 14

TOPIC: *IPC/C and Special Populations*

TIME: Three hours

OVERALL GOAL: To help service providers have more effective interpersonal communication and counseling interactions with special populations that have special needs.

OBJECTIVES: By the end of this session, participants will have:

1. Discussed the importance of recognizing the needs of different groups which should lead to more sensitive and appropriate counseling.
2. Described the unique characteristics and concerns of special needs groups.
3. Identified the specific counseling issues of these special needs populations.
4. Reviewed challenging moments during counseling.
5. Practiced counseling with special needs groups.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction	15 min	Exercise	
2. Special Populations: Why are they special?	20 min	Small groups, large group	Flipchart, Markers Power Point
3. Counseling Special Populations	30 min	Discussion Presentation	Flip chart, Markers
4. Challenging Moments in Counseling	45 min	Discussion	
5. Practice Counseling	60 min	Group practice	
6. Conclusion	10 min		

OVERVIEW: This session will discuss the importance of service providers to recognize the special needs of certain clients such as youth, men, and groups at high risk for STIs in order to provide them with more effective IPC/C services. Participants will practice counseling with these types of clients through role-plays.

1. INTRODUCTION

Begin this session by explaining that during counseling, service providers encounter all kinds of people, some of whom they have a lot in common, others they may have very little in common. However, effective communicators are always trying to understand their audiences, those with whom we communicate. This session is about learning how to interact compassionately with particular audiences who have special reproductive health needs: *adolescents, men, groups at risk of STIs, and people from different religious or socio-economic backgrounds.*

Exercise

1. Ask participants to describe the “typical” family planning client. What are the demographics/ethnographic characteristics of this person?
2. List all responses in the flipchart. (Married women of reproductive age, mainly urban.....)
3. Ask if the person is like them? List responses.
4. Ask participants to name other types of people who need counseling in reproductive health and family planning services.

Married men, young single women, young single men, youth, rural men and women, women with multiple sex partners, men with multiple sex partners, people from different religion, socio-economic backgrounds, etc.

Review with participants the definition of counseling from previous sessions:

Counseling is one person helping another person make a decision or solve a problem with the understanding of facts and emotions involved.

The definition of counseling does not change when counseling someone different from you. The concept of counseling applies universally to all those in need of counseling despite their needs. We will continue discussing this topic later.

2. SPECIAL POPULATIONS: WHY ARE THEY SPECIAL?

Discussion

Ask participants *what is a special population with regard to reproductive health?*
Record the ideas generated on a flipchart. The discussion should bring out that special populations are those who:

- ❖ Are likely to be overlooked by traditional family planning approaches
- ❖ Have unique characteristics
- ❖ Have specific needs

TRAINER'S NOTES

Members of certain client groups have something in common either because they are at a particular time in life (adolescents), they are of the same gender (men), they belong to the same ethnic group (Igbo), or they have experienced a similar life experience (having a baby, having an abortion).

Understanding common experiences and needs of these different groups can lead to more sensitive and appropriate counseling.

Ask participants to discuss *the need for specialized counselors in clinics*

Response:

Specialized counselors are not needed to work with special populations. However, counselors at sites that offer particular services may be more likely to see certain clients than are other counselors. For example, facilities that serve pregnant and postpartum women or people living with HIV/AIDS need to consider how to counsel these clients.

The skills and attitudes needed for counseling clients from special populations are the same as those needed for other kinds of clients. All the skills the service providers learned in the workshop still apply, as do the basic principles and steps of counseling.

Steps to successful counseling across social differences and special populations are:

- 1. Awareness of our attitudes and values about these clients**
- 2. Knowledge of the needs of special populations**
- 3. Skills to balance biases and stereotyping**

When counseling clients from special populations, the attitudes needed such as empathy and openness, are the same as those needed for all clients.

However, some providers find that they may not feel comfortable working with certain populations. This is often a function of exposure and practice. Or they find that their own values come into play with certain client groups, such as persons with multiple sexual partners or adolescents who are sexually active. It is important for counselors to be aware of any views they hold about different types of clients, so that they do not let those views interfere with treating clients with respect and without judgment. Think back to our values clarification exercise...

The purpose of this exercise is to explore with participants the importance of being aware of their own attitudes, values and perceptions and how they can help or hinder the counseling

process.

Remind participants that counselors must remain non-judgmental, putting themselves in their client's shoes. Our attitudes, values and perceptions greatly influence how we counsel clients. If we allow our attitudes and values to influence our counseling relationship, it is unlikely that we will attain our primary goal of helping the client.

Ask the participants to take time to complete the worksheets in their manual that relate to their own biases towards men or adolescents (pages 139 and 140). This will help them be a better counselor for these groups when the need arises.

Counselors do need additional knowledge to counsel special populations. For example, they need to know which contraceptive methods are appropriate to use while breastfeeding; they need to know the typical concerns of unmarried adolescents; or the importance of addressing dual protection for those at risk of unplanned pregnancy or STIs.

Small Group Brainstorm

Divide participants into different groups and assign each group a client population: a) Adolescents, b) Single young men, c) Single young women, d) Men.

Ask them to respond:

- ❖ What are the special **characteristics** regarding sexual behavior and reproduction that is important to each group?
- ❖ What **needs** do we need to consider in counseling the population you have been given?

Ask the groups to answer the questions for their population. They have 15 minutes.

Large Group Discussion

Ask the groups to rejoin and present their lists. Discuss the characteristics of sexual behavior and reproduction. Add/subtract to the list as needed.

Adolescents:

- ❖ Adolescents may be most comfortable with methods that are unlikely to be detected (such as injectables, Norplant implants, or IUDs), or those used only at the time of sexual intercourse (such as condoms or spermicides), or that are easily obtained (such as condoms).
- ❖ Adolescents do not fully understand that they will be sexual beings their whole lives; they do not have to try or understand everything now.
- ❖ Adolescents may not understand that they may be carrying out behaviors that put them at risk for an unplanned pregnancy or STI.
- ❖ Adolescents have incomplete views of relationships, marriage and parenthood.

- ❖ Most adolescents are not ready for sex.
- ❖ Adolescents have gaps in knowledge about reproduction and sexuality.
- ❖ Adolescents have to deal with multiple issues such as sexuality, self-esteem, appearance, being normal within their peer group, and pressure from peers or partners.
- ❖ Health care providers need to accommodate adolescents' needs for privacy.
- ❖ Adolescents prefer to be counseled in places where they gather, such as schools, clubs, or community centers.
- ❖ Adolescents do not feel comfortable attending adult RH and family planning centers.

Men

- ❖ Men often have less information or are more likely to be misinformed about FP methods, male and female anatomy, and reproductive functions than women.
- ❖ Men are often more concerned about sexual performance and desire than women.
- ❖ Men may ask more sensitive and difficult questions, seek the counselor's opinion more often and raise broader issues: economic difficulty, politics, social issues, rumors.
- ❖ Men may have serious misconceptions and concerns that FP methods will negatively impact their sexual pleasure and/or performance.
- ❖ Men are often concerned that women will become promiscuous if they use FP.
- ❖ Men may not know how to use condoms correctly.
- ❖ Men may not be comfortable going to a health facility, especially if it serves women primarily.
- ❖ Men may not discuss FP with their partners.
- ❖ Men often dominate the decision over the right of women to use RH services and FP methods.

TRAINER'S NOTES

Reproduction and Sexual Health are the capacity to reproduce and the behaviors and attitudes that make sexual relationships healthy, both physically and emotionally. Specific aspects of sexual behavior and reproduction that are important to discuss with **youth** are listed below:

1. *Factual information about reproduction* is necessary to understand how male and female reproductive systems work and how conception occurs. Adolescents typically have inadequate information about their own or their partners' bodies. They need the information that is essential for making informed decisions about sexual behavior and health.
2. *Feelings and attitudes* are wide-ranging when it comes to sexual behavior and reproduction, especially health-related topics such as sexually transmitted diseases (including HIV infection) and the use of contraception, abortion and so on. Talking about these issues can increase adolescents' self-awareness and empower them to make healthy decisions about their sexual behavior.
3. *Sexual intercourse* is one of the most common human behaviors, capable of producing sexual pleasure and/or pregnancy. In programs for young adolescents, discussion of sexual intercourse is often limited to male-female vaginal intercourse, but all young people need

information about the three types of intercourse people commonly engage in: oral, anal and vaginal.

4. *Contraceptive information* describe all available contraceptive methods: how they work, where to obtain them, their effectiveness and side effects. The use of latex condoms for disease prevention must be stressed. Even if young people are not currently engaging in sexual intercourse, they will be in the future. They **must** know how to prevent pregnancy and/or disease.

3. COUNSELING SPECIAL POPULATIONS

Regarding the counseling needs of each group, the points listed below should emerge, or you can introduce them, if necessary.

Below are special counseling concerns for key audiences: men, and adolescents.

Discussion

Ask participants to represent their list of counseling needs in each group.
Thank participants for their work.

TRAINER'S NOTES

Youth

1. Messages and the messenger must be credible
2. Use concrete, non-technical language
3. Explore actions which avoid dependence on long-range planning
4. Counselor, know yourself! Values make a difference
5. Keep in mind the idea that sexual activity may not be voluntary

Young Clients Can Make Decisions: A counseling relationship assumes that it is the clients' responsibility to make decisions.

The counselor's first task is to establish rapport with the young client. Communicating caring and receptivity through verbal and non-verbal behavior will influence the meeting's success. Especially with young clients, the counselor is the expert-partner who helps, not the one who directs, criticizes or makes the decision that might be socially appropriate but that the young client won't implement after the counseling meeting.

The counselor and client exchange information and discuss the client's feelings and attitudes about the client's problems. They are partners, but it is the client who knows her world best and is the decider. Throughout, the counselor adapts the counseling process to each of the client's needs. Through this interaction, the client makes a decision, acts on it, and evaluates his or her action.

Counseling Men

Research shows that men behave differently from women in counseling sessions. Research also shows that counselors relate differently to male clients than they do with female clients. Some key findings are:

1. Men communicate more actively in counseling than do women. Men interrupt or disagree more with the counselor. Men ask more questions, seek the counselor's opinion more, and express worry more. Men raise a broader range of issues: economic difficulty, politics, problems of population growth, social issues, rumors about contraceptives.
2. Men ask more detailed questions. Providers give more technical responses to men. They give men more detailed information on anatomy and physiology and on how methods work.
3. Men ask more sensitive and difficult questions about sexual pleasure and sex drive. Men find decreased sexual pleasure to be a highly unacceptable feature of fertility regulation, while women are more concerned with a method's efficacy and side effects.
4. Men seldom directly state the needs, purposes or expectation of the visit. Men often indirectly indicate needs by asking questions or stating opinions, placing responsibility on the provider to interpret and respond. Male clients seldom make an action plan, if no method was chosen.
5. Outcomes of counseling men are more information-gathering, while those of women are more decision-making.
6. Providers respond to men differently than to women when the client communicates actively. They give more supportive responses to men. They ignore and disagree more with women. Providers seldom explore reproductive goals with men. They do more, however, with men in terms of educating and advocating.

Exercise

If there is no time during the session, this can be completed at another time by the participants. This is an individual exercise.

Individual Exercise

Ask participants to read and answer the questions on their manual that talks about Personal perceptions, values and attitudes for youth, for adolescents and for men.

If they do not have enough time, they can finish the questions after the session is over.

4. PRACTICE SPECIAL POPULATIONS COUNSELING

Role Play

Ask participants to divide into teams of three. Give each team the role plays from this page

below. Participants will select **three** of the counseling situations. For each situation they choose, one participant will play the service provider, another the client and the third will observe. With each new situation, participants should change roles. At the end, each participant will have played each part once. The observers should provide feedback to the service provider at the end of each situation.

Bring the group back together. Ask for volunteers to discuss the experience. What was difficult? What was easy? How was this experience different or similar to previous role-plays? How did you feel as the provider? How did you feel as the client? What will you do differently in your counseling of these special populations when you return to your clinic?

Role-Plays: Special Populations

You and your team members should choose three of the following four role-plays. With each situation, one person will play the service provider, one person the client and one will observe. At the end of each role-play, the observer will provide feedback to the “provider.” For each new situation, change roles.

1. Sarah is 16 years old. When she arrives in your clinic she seems nervous and distracted. She says she is having some pain in her stomach, but seems vague about what is wrong. You suspect that the stomach pain is not why she came to the clinic.
2. Maryam is coming in for her follow-up visit after having her second abortion. She seems excited and relieved that she is not pregnant anymore. She reassures you that this won't happen again, but she hasn't mentioned anything about using contraceptives.
3. Ladi is 17 years old and says she wants to marry her boyfriend. They have been together for a year now and according to her “everything is absolutely wonderful.” Can things really be so wonderful? Why is she in a hurry to marry him?
4. A couple in their mid 20s comes to the health facility. During the counseling session, the husband says he wants to have a male child. The wife wants to postpone her next pregnancy. How should the counselor respond?
5. Ibrahim is married with four children. He arrives at the health center seeking information about STIs/HIV. How can you help him?

Special aspects of counseling youth include:

1. Messages and the messenger must be credible
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Personal perceptions, values and attitudes (youth)

1. What perceptions, values and attitudes do I hold that help when I counsel youth?

2. What perceptions, values and attitudes do I hold that may hinder my effectiveness when I counsel youth?

3. Ways I can balance the perceptions, values and attitudes that hinder my effectiveness during youth counseling?

Personal perceptions, values and attitudes (men)

1. What perceptions, values and attitudes do I hold that help when I counsel men?

2. What perceptions, values and attitudes do I hold that may hinder my effectiveness when I counsel men?

3. Ways I can balance the perceptions, values and attitudes that hinder my effectiveness during counseling with men?

5. CHALLENGING MOMENTS IN COUNSELING

Discussion

Ask participants to describe *the type of person they do not like to counsel*, or a *type of difficult situation they have experienced* as counselors.

Ask participants to describe how this situation or people make them feel or behave as counselors?

Write responses on the flip chart.

TRAINER'S NOTES

Developing awareness of our own particular dislikes blind spots or fears about making counseling mistakes or dealing with unexpected situations can prepare a counselor to handle difficult moments.

Every counselor deals with inevitable surprises as well as nightmare moments. They are definitely challenging moments. The skill lies in how the counselor recovers from these situations.

Some difficult issues with clients:

- ❖ Silence
- ❖ Client does not stop crying
- ❖ Client believes there is no solution to his or her problem
- ❖ Counselor makes a mistake
- ❖ Counselor does not know the answer to the factual question
- ❖ Client refuses help
- ❖ Client is uncomfortable with the counselor's gender, age, ethnic group etc.
- ❖ Counselor is uncomfortable with the client's gender, age, ethnic group etc
- ❖ Counselor can not establish good rapport
- ❖ Counselor and client know each other socially
- ❖ Client talks continuously and inappropriately
- ❖ Client asks personal questions to counselor
- ❖ Counselor is embarrassed by subject matter

Exercise

Divide participants into groups of five. Using the brainstormed list of challenges, assign one or two challenges to each group.

Ask groups to develop at least three different ways a counselor might handle the situation. Each group writes their responses.

Group Presentation:

1. Group describes the scenario

2. Lists the strategies devised for helping the provider handle the situation

Ask other groups for suggestions to respond to the challenge.

CHALLENGING MOMENTS IN COUNSELLING

This section is to inform the trainer and to help him or her coach the participants on ways to get through challenging moments in counseling. It is FAR too much information to go through word by word in an effective training session. They will have it for reference in their manual, and it should inform the trainer on each issue, not be read to the group.

1. **Silence** - The client is unwilling or unable to speak for some time. This is common among clients who are very anxious or angry. If it happens at the very beginning of a session it is best for the counselor to, after a little while, gently call attention to it, saying perhaps: "I can see that it is a bit difficult to talk (*reflect feeling*). It's often that way when someone first comes to see me. (*Validation*) I wonder if you're not feeling a bit anxious?" Or, alternatively, if the silence seems an angry one (e.g. the client is looking away from you) you might say "You know sometimes when someone comes to see me who doesn't really want to be here, they decide not to say anything. I wonder if that's how you're feeling?" These statements should be followed by another period of silence, with the counselor looking at the client and maintaining body language that indicates a sympathetic interest.

Sometimes silence will occur in the middle of a session. In those circumstances the context is very important, and the counselor will have to judge why it has occurred. It may be because the client is finding it very hard to make an admission of a secret, or that he or she is unhappy with how the counselor has just reacted to something. Generally, it is best to wait, as it is crucial that the client makes the effort to express his or her feelings or thoughts, even though the counselor may initially find it uncomfortable. There are times when a silence is simply the result of thoughtfulness on the part of the client. There is no need to break the silence or indicate in any way that it is not acceptable.

2. **The Client Cries** - A client who starts to cry or sob may make the counselor uncomfortable. A natural response is to try to stop it, perhaps by comforting the client, but that is usually not best in the counseling session. Crying may occur for different reasons. For some it is a very helpful release of emotion, and an appropriate response is to wait for a while, and if it continues say that it is all right to cry and that it is a natural reaction when you feel sad. This gives them permission to express their feelings. The crying will usually cease in a little while. Crying, however, sometimes occurs for another reason. It can be used to elicit sympathy or to stop any further exploration. It may be a way in which the client is trying to manipulate the counselor much the way he or she will do it at home. Again, it is best to let the client cry, indicating that although you are sorry they feel sad, it is nevertheless a good thing to express their feelings. If the client is being manipulative it will soon come to an end, with the client learning that the counselor cannot be manipulated in the same way that others have been.

Some counselors in some cultures will want to comfort the client by touching him or her. While it may be appropriate, touching a client, especially of the opposite sex, should be treated with extreme caution. There are several reasons for this. If the difficulties a client is

experiencing are sexual in nature, touching the client, even in a relatively non-sexual way (such as on the hand, or on the shoulder), may be misinterpreted and frighten the client. The decision should be appropriate to the culture as well as to the gender and age of the counselor and client, but it is important that a professional - not social - relationship be established.

3. **The Counselor Believes there is No Solution to the "Problem"** - This is an anxiety often expressed by trainees and results in their becoming "stuck", i.e. not knowing how to proceed. It is important to remember that the primary focus of counseling is on the person, not the problem. Even the most intractable difficulties, including the recognition by a client that he is homosexually-oriented when he doesn't wish to be; a young girl wanting to have an abortion when it is impossible to obtain one; or even a person facing untimely death in the knowledge that she/he has become infected with the HIV virus, do not mean that the counselor cannot help the client. One of the most appropriate ways to deal with a client who insists on a solution to the problem as he or she defines it, is to say that while you may not be able to change some things, in your experience, it is always helpful to get to know the person better, and sometimes the perspective on things changes. In practice sessions, it is not uncommon for a participant role-playing a counselor to quickly make some mistaken assumptions. A girl is anxious about what has happened with her boyfriend. The counselor quickly jumps to the conclusion that she is pregnant. An adolescent hints at incestuous feelings. The counselor assumes sexual intercourse has taken place, etc. The more the client is able to explore him or herself, the more possibilities will exist for dealing with the difficulties, including their underlying causes.
4. **The Client Threatens Suicide** - This is perhaps the most anxiety provoking situation for a counselor. Most young people who threaten suicide do not commit suicide, but are nevertheless desperate enough to cry out for attention in this way. There are some things a counselor needs to remember. It is virtually impossible to stop anyone from committing suicide who wishes to do so. A panic reaction on the part of the counselor may be more frightening to the client than a measured one. It is appropriate to say that while no one can stop a person from taking his or her own life, you would feel terribly sad if that were to happen. You are just getting to know each other and you see much that you like and admire in the client. Those who commit suicide are often hopeless. They feel that they have no relationship with anyone who cares. The lifeline that the counselor throws to the client is that he or she does care and that lifeline may give them sufficient hope to continue living.

Some young people threaten suicide in a manipulative fashion to get their own way. They are equally in need of help but must be shown that there are other ways to get the attention and concern they need. A client who has very little self-esteem will not believe that anything but a threat of suicide will matter to others--perhaps it has worked in the past, but it should not work in the same way with the counselor. A comment indicating positive feelings about the client, not about the threat, is the most valuable approach.

It is not uncommon for such a threat or hint of suicide to occur just at the end of a session. The reason for this is that the client feels "safe" enough to raise it because she/he knows the session is about to end and will not have to talk about it at the time. It is best for the counselor to indicate that what the young person has said is very important, that you are

glad he has been willing to share his feelings with you on such an important issue, and that he come to the next session. It is then important to confirm the next session with the client. An inappropriate reaction is to panic and say "if you feel that way, don't go, we had better do something about it right away." Even if you prolong the session at that point, it may communicate panic and not be as helpful as the measured reaction that expresses concern and faith that the client will return.

Because suicide is so tragic in the young, each counselor will have to make his or her own judgment as to the best way to deal with it. The better the rapport with the client, the less likely it is to occur, so emphasis needs to be placed from the very outset on the establishment of that rapport. It is the best protection against suicide in the client.

5. **The Counselor Makes a Mistake** - There are many ways in which the counselor can make a mistake. He or she may make a factual error about something the client has said earlier. The counselor may provide some incorrect information. The counselor may become inappropriately embarrassed or angry at something the client has said. The single most important rule in establishing a good relationship with the client, the kind of relationship that you want him or her to have with other people, is to be honest. Basic respect for the client is one of the key principles of counseling. That respect and confidence in the client can be best demonstrated by admitting that you have been mistaken. An apology is appropriate if you were wrong. Factual errors are easiest to deal with. You might say: "I am sorry, I'd forgotten that you told me you have a younger brother." If you do something which you regret--perhaps getting angry at a client who is being provocative, it is also appropriate to acknowledge that. You might say: "You know, a moment ago when you said that you didn't see how I could help anyone your age because I was too old to know how a young person feels, I was angry for a moment. Perhaps you noticed it. It's a natural way to react, but it's not really fair to you. After all, why wouldn't you think that? I have a different idea about that since I think that people have the same kinds of feelings at any age, although the things they care about may be different. Would you like to talk about that?" You can be sure that any emotional reaction you express, unwittingly or otherwise, will be perceived by the client in some manner even without being fully aware of it. The more openly you can deal with your feelings when it is appropriate (without making personal revelations about your life outside the session), the better example you will be providing to the client to do the same thing. The counselor's mistake can be turned to the good of the client.
6. **The Counselor Does Not Know the Answer to a Factual Question** - This is a common anxiety expressed by counselors. As with the above circumstances, it is perfectly appropriate to say that you don't know the answer but will try to get the information for the client, if it is appropriate for you to do so. You may alternatively identify another source of that information for the client. Evading the question or answering without adequate knowledge will do far more harm to the all-important relationship you are establishing with your client than simply admitting your lack of knowledge.
7. **The Client Refuses Help** - Gently probe as to the reason. In discussing the Initial Interview, it was noted that one of the most important first tasks is to establish why the young person has come. Many clients are sent for help when they may not want help. Helping the young person say why they are there will usually open the subject up. It is then appropriate to say something

like: "Well, I can understand how you feel. I'm not sure whether I can help, but perhaps we could take a few minutes just to see what you think, and together we can decide if it might be worthwhile to talk a bit more." Often the client will say that something like "My father thinks I have a problem with this boy at school, but I really don't. He just won't listen when I tell him." The client may be quite right, but she may instead be experiencing difficulties in her relationship with her father, and the skilled counselor may be able to help her remain in counsel to deal with that. If the client is completely unwilling to talk, stress the positive that at least he/she did come, you've met each other now, and maybe he/she might like to reconsider. Suggest another appointment and try, if possible, to leave it open. The client then has a "lifeline" and may indeed return.

8. **The Client is Uncomfortable with the Counselor's Gender** - This difficulty may be made explicit if the client says, "I don't think I can talk to a woman (or man) about this" or "I was expecting a woman (or man)". It may not be stated but sensed by the counselor. If this is the case, it is best for the counselor to raise the issue by saying something like - "I wonder if you were expecting to see a man (or woman)?" Once the issue is in the open, it is appropriate to say something like "Some young people are, at first, more comfortable with someone of the same (or opposite) sex, but in my experience that usually becomes less important once they get to know each other. Why don't we try to continue, and see how we get on?" The client will usually accept that, and the problem is likely to vanish if the counselor is attentive, respects the client, and is non-judgmental. The use of encouragers and reflections are particularly helpful since they give the client a sense that what he or she is saying is acceptable. If the client is adamant from the outset that he or she wishes to see someone of the other sex, and it is possible to arrange that before going any further, it may be necessary to try. But, in fact, it would probably be better for the client to learn to work with a person of the sex which makes him or her uncomfortable. The counselor should therefore first see if the client can be given sufficient confidence to try.
9. **The Counselor is Short on Time** - It is always of benefit to the client to know approximately how much time he or she will have with the counselor, and it is best if that amount of time remains more or less constant. On occasion, it may happen that the counselor has less time than usual. It is then extremely important to say so at the outset, provide the reason, if that is feasible, and apologize, indicating that she or he will hope to meet the client again at a specific time. A great deal can be accomplished even in a few minutes, as will have been demonstrated to the participants in the role-plays. It is best to make use of that time rather than send the client away.
10. **The Counselor Cannot Establish Good Rapport** - Sometimes it may be very difficult to establish satisfactory rapport with the client. This is not necessarily a reason for ending counseling or referring the client to someone else. Rather, the counselor should ask for help from others in reviewing the sessions to understand better where the difficulty may lie. If there is something about the client which the counselor finds himself rejecting, it is essential that it be dealt with, if at all possible. One of the important aspects of training is for the counselor to learn what may make him or her uncomfortable and to try to deal with those issues before beginning counseling, or at least to seek help while working with someone with whom it is difficult to establish rapport.

If, after discussing it with an experienced counselor, the difficulty appears to be that the

client has never been able to have a close relationship with anyone, sending the client away or to someone else will not help, but is likely to damage the client. It is far better to try to continue, especially by helping the client to feel better about him/herself.

- 11. The Counselor and Client Know Each Other** - It is quite common in small communities that a client will know who the counselor is and may know him or her quite well. If the relationship is a casual one, it may be possible to serve as a counselor, but it must be made clear early on that confidentiality will be completely respected, and that the way you will relate to your client is quite different from the way you would relate to a friend or acquaintance. If, however, you are well known to each other, it is not possible to serve as a counselor. It will be necessary to explain that to the client and arrange for someone else to help. The counselor must indicate that in his/her experience, it is not helpful to work with someone he/she knows well. The role of a counselor is a different one. It is not possible to change roles when meeting outside the counseling session, and this will inevitably give rise to confusion and hurt feelings.
- 12. The Client Talks Continuously and Inappropriately** - This is the opposite of a client being unduly silent or refusing to talk, but it may arise from the same kind of anxiety which makes talking difficult. If a client persists in talking continuously and saying things that are essentially trivial (to the client) and repetitive, it is appropriate to interrupt after some time, and say, e.g., "Excuse me, Maryam, but I wonder if you realize that for some time now you have been repeating the same thing? Are you feeling a bit nervous or finding it hard to talk about other things?" This may help to alter the focus of the conversation from something outside the session to the client herself, which may be sufficient to halt the flow of inappropriate talk.
- 13. The Client Asks a Personal Question of the Counselor** - A counselor-client relationship is a professional one, not a social one. This is valuable because it enables the counselor to react in different ways than the other people in the young person's life, and can help the young client learn more constructive and rewarding ways of relating to people. This may be difficult for the client to understand at first, especially if the counselor is being warm and caring at the same time. One hazard to this relationship is responding to personal questions from the client about oneself. This is almost never advisable for several reasons. It takes attention away from the client. It may lead to a series of questions which, while starting innocuously, may end with very private matters which the counselor then refuses to answer. This gives the wrong message to the client, suggesting that something is wrong, either with the counselor or with the client, for being concerned about such things. Sometimes the client will want to know if the counselor has the same problem. Saying "yes" may make the client feel that counselor will not be able to offer help with that particular problem, while saying "no" may make the client feel the counselor does not understand the problem. It is far better to respond to a personal question by saying that it is not helpful to the client if the counselor talk about him/herself and that is why he/she makes it a rule not to. The client will accept that rule. It is far better than either answering some but not all questions, or, worse, evading the issue, which will destroy the honesty of the relationship.
- 14. The Counselor is Embarrassed by the Subject Matter** - It may happen that something the client says embarrasses the counselor. The more training he/she has had in sensitive subjects, the better he/she will be able to identify areas in which he/she feels most vulnerable, and the less

likely he/she is to be unprepared. Nevertheless the counselor may be embarrassed. It is always best for the counselor to be honest with the client, especially if he/she has responded emotionally, since the client will be aware of it. This can be turned to an advantage, by acknowledging having had such a feeling and then returning to the subject if the client has raised it. The counselor may wish to say something like: "You may have noticed that when you mentioned the fact that you were masturbating, for a moment, I was taken aback. That sometimes happens when people aren't expecting something, but in fact, I'm glad you brought it up. Maybe it would be useful to talk about that." After the session it may be helpful to talk with whoever is providing supervision about what happened, and see if such uncomfortable feelings can be overcome.

6. CONCLUSION

Application

- Highlight the major lessons and points in the session. Invite participants to share their reactions and thoughts.
- Ask participants what new ideas they have learned or perhaps lessons they have remembered as a result of the session.
- Ask what behaviors they think will be easy to put into practice and what do they think will be difficult.

Evaluation

Ask the participants again for some of the needs of special populations, especially married and unmarried youth.

Summary

- Review the objectives of the session with the group.
- Link it with the next session on Integrated Skills Practice



Day 4 - SESSION 15

TOPIC: *Integrated Skills Practice*

TIME: Two hours

OVERALL GOAL: Participants will apply the IPCC skills learned in an integrated fashion before they return to work.

OBJECTIVES: By the end of this session, participants will have:

1. Reviewed GATHER Counseling-Skills, and Effective Use of IEC Materials.
2. Discussed importance of effective feedback
3. Practiced integrated counseling skills with use of IEC materials for effective counseling.
4. Used the observation checklist and provided effective feedback.

OVERVIEW: This is a key session to pull together all the skills learned during the workshop. Emphasis should be on working out any last questions or clarifying any last skills before participants return to their work site.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction and Review	15 min	Group discussion	
2. Integrated Skills Practice	60 min	Small Group Practice	
3. Use of Observation Checklist	30 min	Small Group Practice	
4. Conclusions	15 min	Large Group	

1. INTRODUCTION

During this session, participants not only integrate cognitive information learned during the workshop, but also integrate the discrete skills taught during specific previous sessions, increase awareness of their counseling strengths and weaknesses and become more skillful observers of the counseling process. This session aims to pull together everything shared thus far.

TRAINER'S NOTES

A crucial component of the counseling training workshop is supervised practice. Even though initial sessions are designed to be participatory and experiential, participants learning to counsel effectively need the opportunity to integrate all the counseling skills by practicing and receiving feedback on their performance. The workshop design allows for the participants to observe others counseling and to be observed themselves.

Discussion and Review

Ask participants to describe the key components of effective counseling (review of GATHER).

Then ask participants about the key counseling skills that they have practiced that are incorporated into every GATHER session.

Next, ask participants to describe the key principles in using IEC materials during counseling situations.

Last, ask for any questions and clarify if necessary.

2. IMPORTANCE OF FEEDBACK

Ask participants what do we mean by feedback?

Record their answers on the flipchart.

FEEDBACK

is the communication to a person or to a group of people about the effect of the behavior of the person, or group on another person.

Another definition is:

Feedback is information/a message which is given to someone about the result and quality of work. Good feedback will give encouragement to that person to maintain what has been considered good and at the same time, to use the suggestions to increase knowledge or their skills in the future.

Ask participants if they have ever received feedback from their supervisor on their performance?
How did they feel? Why?

Ask their opinions about giving good feedback. Write their answers on flipchart/ board.

Sometimes the feedback makes the receiver feel bad because it is negative.

Negative feedback has consequences:

- Makes the receiver feel guilty
- May communicate lack of respect for the other person
- May lead to a negative reaction
- May lead to a resistance in behavior change
- May make the receiver feel bad
- May lead to lower self esteem of the receiver
- May make receiver resentful

As we can see, giving feedback is not easy. But effective feedback allows us to grow and to learn from experiences. The goal of positive and constructive feedback is to bring about changes in our attitude and behavior.

How to give effective feedback:

Acknowledge the need for feedback

The first thing to do is recognize the value of feedback, both positive and negative. Feedback is vital to anyone committed to improve oneself, for it is the only way of knowing what needs to be improved.

To be effective, feedback should be:

- **Specific:** Explain accurately what has been done well and what can be improved. Many people take good work for granted and give feedback only when there are problems. People will more likely pay attention to your complaints if they also receive your compliments. It is very important to remember to tell people when they have done something well.
- **Constructive:** Explain with positive terms/ words about what can be done better in the future.
- **Pleasing:** Give feedback where one will not feel disgraced. It is important to understand the context under which feedback is given: where it happened, why it happened, what led to the event. You never walk up to a person, deliver a feedback statement and then leave. Before you give feedback, review the actions and decisions that led up to the moment.

Individual feedback also depends on the level of knowledge and skills currently possessed by that person. Beginners should be given verbal encouragement for each improvement he or she makes, no matter how small it is. Respect and give compliments to the individuals who do good and correct work, no matter how trivial it may seem.

In order to change others, we must first change ourselves.

Know how to give feedback:

- Be descriptive
- Be specific and give examples
- Phrase the issue as a statement not a question
- Don't exaggerate
- Don't judge
- Speak for yourself
- Help people hear and accept your compliments when giving positive feedback

Know how to receive feedback

- Thank the person for the feedback
- Be positive
- Do not justify yourself

FEEDBACK AFTER THE WORKSHOP

Mention that the feedback process should not end with the workshop. As we know, practice makes perfect. Participants should be encouraged to think of a way to continue receiving feedback on their IPC/C skills when they are back in their clinics.

Divide participants in pairs and ask them to make some suggestion on how to continue the feedback process after the workshop.

Give them 5 minutes.

Ask participants for their suggestions.

Write their responses in the flipchart.

Discuss the potential of carrying out some of the suggestions.

Some Suggestions:

Have participants from the same clinic team up as partners and work together to improve their skills by providing each other with feedback after role playing a counseling interaction once they are both back at their facilities.

Review the attached form (page 155):

PERSONAL PLANNING WORKSHEET FOR TRANSFER OF LEARNING

3. INTEGRATED SKILLS PRACTICE

Role Play

This section will focus on a counseling situation with clients. Ask participants to form groups of three. One participant will role-play the provider, one the client and one will be the observer (using the **Observation Checklist**).

The “provider” will select a situation that he/she wishes to practice, perhaps a situation he/she has experienced before and wants to practice again. The “client” will role-play the client as described by the “provider.” Be sure to focus on the counseling skills and appropriate use of IEC materials to support the situation. The role-play will last 5 minutes. At the end, the observer will present his/her feedback, written and verbal (two minutes) using the observation checklist form.

Then the provider will present his/her own feedback on the interaction.

Then the groups will shift roles, with a new provider, client and observer. Repeat the process again.

Lastly, the groups will shift roles again and repeat the process a third time. By the end, each participant will have played each role.

4. CONCLUSION

Application

Ask volunteers to describe one strength they now have for giving effective counseling and one area (skill) they would like to strengthen. Ask them to identify what would keep them from implementing this skill in their work situation.

Summarize the major points of the session.

Evaluation

Ask participants again for some of the skills in effective counseling and the importance of feedback

Summary

Review the objectives of the session with the group

Link the session with the next one on Reaching out to the community

EFFECTIVE FEEDBACK

1. Feedback is the communication to a person or to a group of people about the effect of the behavior of the person or group on another person.

2. **Feedback** is information/a message which is given to someone about the result and quality of work. Good feedback will give encouragement to that person to maintain what has been considered good and at the same time, can use the suggestions to increase knowledge or their skills in the future.

The goal of positive and constructive feedback is to bring about changes in our attitude and behavior.

How to give effective feedback:

Acknowledge the need for feedback

The first thing to do is recognize the value of feedback, both positive and negative. Feedback is vital to anyone committed to improving oneself, for it is the only way of knowing what needs to be improved.

To be effective, feedback should be:

- . **Specific:** explain accurately what has been done well and what can be improved. Many people take good work for granted and give feedback only when there are problems. People will more likely pay attention to your complaints if they also receive your compliments. It is very important to remember to tell people when they have done something well.
- . **Constructive:** explain with positive terms/ words about what can be done better in the future.
- . **Pleasing:** give feedback where one will not feel disgraced. It is important to understand the context under which feedback is given: where it happened, why it happened, what led to the event. You never walk up to a person, deliver a feedback statement and then leave. Before you give feedback, review the actions and decisions that led up to the moment.

Individual feedback also depends on the level of knowledge and skills currently possessed by the person. Beginners should be given verbal encouragement for each improvement he or she makes, no matter how small it is. Respect and give compliments to the individuals who do good and correct work, no matter how trivial it may seem.

In order to change others, we must first change ourselves.

Know how to give feedback:

- Be descriptive
- Be specific and give examples
- Phrase the issue as a statement not a question
- Don't exaggerate
- Don't judge
- Speak for yourself
- Help people hear and accept your compliments when giving positive feedback

Know how to receive feedback

- Thank the person for the feedback
- Be positive
- Do not justify yourself

Easy Steps to follow:

Start the feedback with positive feedback:

When you _____ (do this specific facts)

I feel _____ (emotion) because _____

How about _____ (give an alternative)

PERSONAL PLANNING WORKSHEET FOR TRANSFER OF LEARNING

My Personal Learning Goals (areas where I'd like to improve my counseling, knowledge, skills and attitudes) Be specific, concrete, and realistic.	By when will I take these actions?	Resources or Opportunities available to me	Person(s) who can give me feedback in this area

Day 4 - SESSION 16

TOPIC: *Reaching out to the community*

TIME: Two hours

OVERALL GOAL: To help the service providers have more understanding of the need to interact with the communities they serve for the success of their programs

OBJECTIVES: By the end of this session, participants will have:

1. Explained the meaning of “Community”;
2. Described the “Profile” of their community.
3. Discussed at least 6 benefits of interacting with the community.
4. Identified opportunities for provider and community interactions.
5. Identified some of the barriers to provider and community interactions;
6. Discussed ways of motivating providers to reach out to and interact with the community;
7. Identified ways to incorporate provider and community interactions at the participant’s work site.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction and Review	20 min	Group discussion	Flip chart, Markers
2. Ambassadors of Health	25 min	Group discussion Small Group	Flip Chart, Markers
3. Interacting with the Community	30 min	Small Group	Power Point Flip chart, Markers
4. Barriers to interacting with the community	30 min	Small Group	Power Point Flip chart, Markers
5. Conclusions	15 min	Large Group	

OVERVIEW: This session will discuss the need for service providers to know the communities they serve and use this knowledge to plan their health programs. They will identify opportunities for provider-community interactions. The session will also identify the barriers to community participation in health programs and will discuss ways of overcoming them.

1. INTRODUCTION

- Display **slide** with session objectives
- Ask volunteer to read
- Check if objectives are clear
- Clarify as necessary

THEN:

- Ask how any of the trainees would react and feel if appointed by the President of the Federal Republic of Nigeria as an envoy, ambassador or emissary to a country they have secretly desired to visit.
- Ask trainees to explain what would be expected of them
- What would they need to carry out this assignment efficiently?
- Tell trainees they are already ambassadors of health for their community
- Introduce topic.

TRAINER'S NOTES

Ambassadors for Health

Quality of service is closely linked to the ability of the targeted consumer to be able to benefit from the services so provided. Ensuring access to services means making good quality affordable care available where and when convenient to the community.

Access is more than the existence of a convenient health facility. When the facility lacks properly trained staff, has inconvenient hours, lacks supplies, charges high prices, or staff do not respect clients' rights or do not make them feel welcome, the community does not have adequate access to services. Often health facilities are organized more for the convenience of the providers and providers think they know what is best for clients and the community. Just as in the counseling situation, where the client best knows his or her needs and situation, the community knows its needs and concerns and often has much to contribute to designing and implementing effective health services.

If interactions with clients are confined to the health facility alone, opportunities will be lost to reach potential clients, provide important health information, receive feedback about services, learn what the needs and expectations of community members are, identify possible barriers that may be reducing access to and utilization of services, and finding mutually acceptable and effective ways of reducing these barriers.

Service providers have a wealth of health information that needs to be shared and disseminated whenever and wherever possible. Service providers need to become **“Ambassadors for Health”**, who seek every opportunity to teach others about health, correct misinformation and rumors, and promote healthy behavior. In order to accomplish this goal, providers must not confine or compartmentalize their health service roles to the time spent within the confines of the health facility setting. They need to integrate their role as health providers with their other roles in the community. In a previous session, the service provider is assisted in bringing qualities of “caring” to the client provider relationship. It is reasonable to assume that these “caring” individuals also care about the communities in which they live and work, and the members who comprise that community. In this context, the provider can demonstrate his/her “caring” by interacting with the community.

The results of these interactions should include increasing people’s information and understanding about important health issues, improving the image of health care providers, increasing utilization of health services, promoting prevention and reducing curative and emergency requirements, and increasing the satisfaction of community members with the care and services they receive.

2. “AMBASSADORS OF HEALTH”

Discussion

- Ask trainees to generate ideas about their roles as ambassadors of health at the facility level and at the community
- Ask trainees what they understand by ‘community’ and lead a discussion on the importance of knowing about your community, and how it enables you to provide better health care.

TRAINER’S NOTES

Definition of “Community”: “A social group of people living in a geographical area who have similar interests and needs, a common culture and a shared government”.

Although communities have a lot of common characteristics and similarities, there are also differences that need to be understood and taken into consideration when providing health services. The characteristics that make a community unique make up its identity or profile. These characteristics might include such things as:

1. Is the community urban or rural?
2. How and where do people work?
3. Who are the people who live in the community?
4. Who are the leaders and opinion makers?
5. Are there special health care needs?
6. Where and how do people receive information?
7. What are cultural practices, local beliefs and attitudes about health practices?

8. What health resources are available?
9. What are their perceived problems?
10. Are there seasonal patterns or other circumstances that affect their life styles and activities?

The service provider needs to learn about and understand the unique characteristics of the community, as these affect clients' needs, use of services, and the provider's ability to access community members.

As a member of the community, the provider probably knows a great deal about the community already. In order to learn more about the community, he/she can:

1. Talk with elected community leaders and opinion makers
2. Talk with leaders of women's groups and attend meetings
3. Talk with leaders of men's groups and attend meetings
4. Talk with leaders of youth groups and attend meetings
5. Talk with religious leaders
6. Move around in the community and observe what is happening
7. Make home visits
8. Participate in community social events
9. Attend Local Council meetings.

3. INTERACTING WITH THE COMMUNITY

Small group discussion

- Divide group into 3 by counting 1, 2, 3....
- Ask each group to come up with reasons why providers need to interact with the community and the benefits to be derived
- Responses to be recorded on FLIP CHART
- All groups to paste FLIP CHART on the wall for all to see

Large group discussion

- All responses to be reconciled on one master sheet
- Display **slide** with reasons and benefits for community interaction
- Fill in the gaps as appropriate
- Trainees to rate the points from the most to the least important
- Trainer summarizes that all points are very important as they all move the clients towards changing behavior or adopting new behavior.

TRAINER'S NOTES

Reasons for Interacting with community

- To help the service provider learn more about the community

Reasons for Interacting with the Community

There are many reasons for interacting with the community and benefits derived from the interactions. These include:

1. Increased awareness of services.

Awareness of health can be increased and more explanation about health services can be provided and explained. Improvements in services that have been instituted can be discussed. Information can be provided about the affordability of services and expected costs (if any). The relationship between value received and cost in terms of effort, time and money can be discussed. Information about when services are available and the integration of services can be made known.

2. Learning community needs and expectations

The provider can be made more aware of what people value and expect from health facilities and providers, as regards health services. She/he can use the opportunity to relate available services to community needs and values and increase a sense of community ownership through participation. Better understanding of community needs, can assist providers in planning services and allocation of resources to address the issue (s). Client satisfaction depends not only on service quality but also on clients' expectations. Clients and the community are satisfied when services meet or exceed their expectations.

3. Providing health messages and information.

Health information and messages received at the health facility can be reinforced and new or updated information can be introduced. What community members already know can be assessed, including effectiveness of information and behavior changes initiated at the health facility. Health talks and information can, for example, promote prevention of maternal mortality and improve access to safe delivery for mothers. Access to information can reduce the amount of new information that is required during counseling, which may conserve client and provider time and reduce information overload. Community health talks and participating in discussions with peers may assist people to either begin or move ahead the steps to behavior change.

4. Dispelling rumors

Rumors are unreliable information passed around the community, mostly by word of mouth. Rumors can become widely known and believed, although they are usually inaccurate or false. They tend to result from traditional beliefs about the body and health, exaggerations to make stories more interesting, unclear or incomplete information from health providers, people trying to explain something they have no obvious explanation for, or intentional efforts to hurt the reputation of a health facility or providers. Rumors can seriously affect utilization of services, carrying out of instructions and treatments, and possibly lead to adopting unhealthy behaviors and discontinuation of treatments and services. In community interactions the provider has the opportunity to:

1. Find credible, respected persons who can tell people the truth, such as community leaders and satisfied clients;
2. Try to find out why the rumor started. Perhaps a real event needs to be explained.
3. Encourage people to check first with health care providers before they repeat rumors.

5. Obtaining feedback about services

Listening to how the community perceived services they received can serve to reinforce positive aspects of services, create awareness of barriers to fully utilizing services and point out opportunities for improvement. Providing an opportunity for discussion, can lead to mutual problem solving to try and reduce barriers.

6. Increasing awareness of what the community can expect from providers and the health facility.

Community members often expect poor quality service and accept it without complaint. It is important to develop an expectation of good quality so that clients know what they should expect and insist on. Sometimes clients' and the community's expectations or perceptions of quality are inaccurate, which in turn can affect provider behavior and actually lower quality. For example, clients sometimes want inappropriate tests, procedures and treatments in the mistaken belief that receiving these things constitutes good care, and providers may comply so as not to dissatisfy the clients. Community health sessions provide a good opportunity to both increase awareness of what can be expected of good quality services, while also correcting misconceptions.

7. Improving the image of the health provider

Interacting with the community demonstrates interest and caring by the provider. As community members get to know providers through these interactions they begin to identify with him/her as "my provider". Going out into the community helps the provider to better identify with and understand the life circumstances of clients and potential clients, which helps the provider to be more empathetic. Seeking opportunities to meet with, talk with and learn from the community helps to bridge the gap between the community and providers, and improve the image of providers held by the community.

- Display **slide** or FLIP CHART with Chinese saying by Lao Tzu
- Discuss Chinese saying to initiate discussion on utilizing knowledge about the community

The provider can use his or her knowledge and understanding of the community and its infrastructure to seek opportunities to access members of the community and interact with them. It allows the provider to go where the people are.

“Go to the people, live with them, learn from them. Start with what they know, build with what they have. When the work is done and the task is accomplished, the people will say ‘we have done this ourselves’ “.

(Lao Tzu, China, 700 BC)

4. BARRIERS TO INTERACTING WITH THE COMMUNITY

Large group discussion

- Ask trainees to generate opportunities available in the community for interaction between the client and the provider
- Display **slide** or FLIP CHART and fill in any gaps evident

TRAINER'S NOTES

Opportunities to interact with community members can be found through using the existing infrastructure such as schools, churches, mosques, cooperatives, women/ men/ youth groups, community meetings, market places, water and firewood collection points, outreach services (e.g., Immunization programs), NGO community initiatives work places, etc. Spontaneous social gatherings such as weddings, graduations, and funerals also provide an opportunity to impart health messages, correct misinformation, and increase awareness of health services.

Actively seeking out leaders, influential people and opinion makers can assist the provider in gaining access to community members, as well as gaining support for promoting healthy behavior within the community. Examples of these significant community figures might include local government officials and representatives, chiefs, health committee members, group leaders, “unofficial” leaders (opinion makers), TBA’s and other traditional healers, religious leaders, etc.

- State that barriers can arise from **the provider and community’s point** of view
- Ask trainees to generate these barriers
- Acknowledge correct responses and write on FLIP CHART
- Display **slide** or FLIP CHART and explain further as necessary

TRAINER'S NOTES

Barriers to provider and community interactions

Barriers to interactions can come from both providers and the community. Both need to be identified and actions taken to try and reduce or eliminate them.

Possible provider barriers:

1. Lack of good client customer focused materials
2. Lack of transport and allowances while away from the work site
3. Multiple time demands at work and in personal life
4. Shortage of health facility staff
5. Lack of support from management for community outreach activities
6. Not knowing how to approach the community or access entry points
7. Concern that the community will have unrealistic demands for interaction such as providing medicines, treatments, etc
8. Lack of experience in talking openly with the community or giving community health talks
9. Fear of being confronted with questions or issues that they lack information about or cannot resolve
10. Language barriers
11. Going outside of the relative “safety” and familiarity of the health facility to provide health information

Possible community barriers:

1. Lack of time or life style circumstances
2. Cultural or religious beliefs

3. Provider's perceived social status, i.e. Social gap
4. Influence of authority figures (e.g. husbands) or influential leaders
5. Gender bias
6. Perception of providers as unfriendly, hostile, etc
7. Not seeing the relevance of proposed health topics or issues to their needs or interests
8. Lack of motivation resulting from attitudes such as hopelessness, "nothing will change", fatalism, etc.

Discussion

- Ask how barriers identified by providers can be overcome
- Display **slide** on overcoming barriers and summarize discussion

4. CONCLUSION

Application

- Ask participants what they feel about community interaction
- Ask participants to reflect on what they have learnt that will influence changes to improve services in general. Summarize the learning.
- Ask participants in what situation they can use acquired knowledge
- Ask for clarifications to ensure applications relate to learning's

Evaluation

- What are the benefits of working in harmony with your community?
- What are the characteristics of Health Ambassadors?

Summary

- Review session objectives checking to what extent these have been met.
- Link to the next session on providing information to the community.



Day 5 - SESSION 17

TOPIC: *Summary of Day 4, Birth Spacing technical overview And Providing Information to the Community*

TIME: Two hours

OVERALL GOAL: To provide technical information for the trainees on the field of Birth Spacing services, and to teach the participants how to effectively provide health information in the community

OBJECTIVES: By the end of this session, participants will have:

1. Stated purposes for providing health information sessions in the community;
2. Discussed steps for planning, preparing, and conducting group sessions;
3. Demonstrated (through role play) ability to:
 - a. conduct planned community health information sessions
 - b. handle spontaneous opportunities/ situations in the community to provide health information
4. Applied principles of interpersonal communication skills when interacting with the community;
5. Identified ways to utilize health information sessions as an opportunity to encourage the community to offer feedback about services and discuss other health issues and concerns.

Notes for the Facilitator:

The first session of each day is relatively flexible – the technical overview will probably not take more than one hour, though there should be time for discussion. In this case, the technical area – Birth Spacing, aka Family Planning – should be fairly familiar to the participants, so please go on to the next module in the training before the coffee break.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction and Review	20 min	Group discussion	Flip chart
2. Opportunities in the Community	25 min	Group discussion Small Group	Flip Chart
3. Creating an interactive	30 min	Discussion	

environment		Role play	
4. Conclusions	15 min	Large Group	

OVERVIEW: In this session, Participants will learn how to determine health information topics, identify the intended audience, plan, conduct, and evaluate health information sessions. They will also learn how to create an interactive environment and the key points to keep in mind when presenting health information.

OVER VIEW OF BIRTH SPACING AND THE CONTRACEPTIVE NEEDS OF YOUNG PEOPLE

Brainstorming

- Ask participants the importance of knowing about contraceptives
- Record their responses on a flipchart
- Discuss the importance and reconcile with their own points

TRAINER’S NOTES

IMPORTANCE OF KNOWLEDGE ABOUT CONTRACEPTIVES

Young people need reliable information about access to contraceptives in order to protect themselves from STIs, including HIV/AIDS, and unintended pregnancies. Information about contraceptives is important for all young people whether they are abstaining from sex or are sexually active.

Brainstorming

- Ask the participants to list the various contraceptive methods they know
- Record responses on a flipchart
- Display **slide** with various contraceptive methods and explain each

- Clarify any doubt or misconception

CONTRACEPTIVE METHODS FOR YOUNG PEOPLE

ABSTINENCE

This is the process of avoiding sexual intercourse until the adolescent is able to have a fully responsible and emotionally fulfilling relationship. It is an important principle that must be promoted in helping a young person to delay the beginning of sexual intercourse. The young person needs to know the consequences of early sexual intercourse especially in biomedical terms, including pregnancies, STIs, HIV/AIDS and high risk of developing cervical cancer for girls in later years. Efforts must be made by counselors to assist young people make choice including abstinence. Abstinence can be further achieved where the young person is equipped with skills that will enable him/her reduce the pressure and also say “NO” to sex until he/she is fully ready.

Skills for effective abstinence

- Being able to talk to each other
- Self control
- A positive vision
- Shared values
- Alternatives
- Partner co-operation
- Information
- Knowledge of consequence
- Ability to define sexual situation

MALE CONDOM

The condom is a rubber sheath worn over an erect penis like a second skin. It holds the semen released during ejaculation to prevent spilling into the vagina during sexual intercourse. Most rubber condoms are coated with lubricant while some have sperm-killing chemicals in the lubricant. When used correctly and combined with foaming tablets, condoms can be highly effective. There is no contact between the man’s sperm and the woman’s egg. A condom is the only method of contraception that also protects against Sexually Transmitted Infections (STIs) including HIV/AIDS.

FEMALE CONDOM

It is a woman – controlled method to protect against STDs including HIV/AIDS and against pregnancy. It is sheath made thin, transparent and soft plastic. Before sex, the woman places the sheath in the vagina. During sexual intercourse, the man’ penis goes inside the female condom.

DIAPHRAGM

It is a dome shaped rubber cup that is filled with spermicide and inserted to cover the cervix before sexual intercourse.

SPERMICIDE

These are products that contain sperm-killing ingredients (spermicide). They are inserted into the vagina before a woman has sex. They are very effective when used in combination with condoms/diaphragms.

Types:

- Aerosol Foams
- Vaginal tablets
- Jellies, Cream

PILLS

Pills are tablets containing hormones – oestrogen and progesterone normally produced by the woman’s own body. The pills prevent ovulation so that the ovaries do not release eggs and pregnancy can not occur. One pill must be taken every day.

PROGESTERONE ONLY PILL (POP)

POPs only contains a progestin and are taken daily. They include Overette, Micronor, and NORQD.

Mechanism of Action

- Suppresses ovulation
- Thickens cervical mucus to prevent sperm entry into the upper genital tract
- Inhibits ovulation

COMBINED ORAL CONTRACEPTIVE (COC)

These pills contain oestrogen and progesterone. There are two types of pills. One of these has 28 pills i.e. 21 ‘active pills’ which contain hormones followed by 7 “reminder” pills of different colour that do not contain hormones. The other type has only 21 “active pills”

Mechanism of Action

- Stops ovulation
- Thickens cervical mucus, making it difficult for sperm to pass through

EMERGENCY CONTRACEPTION

These are appropriate to prevent pregnancy after unprotected intercourse. The approach only reduces the risk of pregnancy but does not cause abortion if pregnancy has already occurred.

EMERGENCY CONTRACEPTIVE PILLS (ECPS)

Regimen 2 large doses of COC with oestrogen and progestin

This should be taken as soon as possible after an unprotected sexual intercourse. 1st doses are taken within 72 hours after unprotected sexual intercourse, 2nd doses 12 hours later. If vomiting occurs, within 2 hours of taking the 1st dose or 2nd, the client may repeat the dose. To avoid vomiting, give antihistamine few minutes before commencing ECPs.

NORPLANT IMPLANT

It is a set of six small, plastic capsules. Each capsule is about the size of a small matchstick, which is placed under the skin of the woman's upper arm.

DUAL PROTECTION

Since there is no single method that is 100% effective against pregnancy and in order to avoid unwanted pregnancy and STIs including HIV/AIDS, “dual protection” is using a method, which is very effective in pregnancy prevention e.g. hormonal contraceptive in combination with another method like condom, which provides good protection against STIs and HIV. Also the singular use of condom protects against pregnancy and STI/HIV/AIDS.

INEFFECTIVE METHODS

Douching

This means washing out of the vagina immediately after having sexual intercourse with the hope of washing out the sperm. This method is not effective because the sperm cannot be flushed.

Rhythm

The idea of this method is that a woman keeps track of her past menstrual cycles and tries to note the days when she is least likely to become pregnant i.e. “safe” days to have sexual intercourse. This may be ineffective for young people for the following reasons:

- Young girls often do not have regular menstrual period and do not ovulate regularly,
- Since sperm lives for 3 – 5 days, it can be easy for woman to get pregnant when they think they are safe – even during their menstrual period.

- Lack of knowledge to calculate accurately the safe period
- Some have short cycles such that even when they are menstruating they are not safe.

Withdrawal

Withdrawal involves removing the penis from vagina before ejaculation takes place. Since a man produces some semen soon after erection, withdrawal method is ineffective. Seminal fluid introduced outside the vagina can cause pregnancy.

OTHER CONTRACEPTIVE

Other methods of contraception are available, but they are often not recommended for youth who have never had children. These methods include intra-uterine devices (IUD), injectable (Depo-Provera and Noristerat), Tubal ligation and Vasectomy

Where to Obtain Contraceptive methods within Society

- Patent Medicine Store
- Maternity Centers
- Youth Friendly Centers
- Village Health Workers/Traditional Birth Attendants/CBD Agents
- Youth Centers
- Hospital
- Peer Educators
- Family Planning Clinics (e.g. Planned Parenthood)
- Pharmacy Stores

1. INTRODUCTION

Review the objectives with all providers and ask if any points need clarification.

2. OPPORTUNITIES IN THE COMMUNITY

Brainstorming

- Ask trainees to generate ideas about reasons for providing health talks at the community
- Display FC and reconcile
- Ask trainees to list advantages and disadvantages of group sessions
- Recap on need to provide information on health issues to the community

TRAINER'S NOTES

Counseling Starts in the Community

Informing the community and counseling clients go hand-in-hand. Health information and messages received at the health facility can be reinforced and new or updated information can be introduced during community group sessions. What community members already know can be assessed, including effectiveness of information and behavior changes initiated at the health facility. Community health talks and information can promote prevention and reduce curative and emergency needs. Access to information in the community can reduce the amount of new information that is required during counseling, which may conserve client and provider time and reduce information overload. Community health sessions and participating in discussions with peers about a health issue may assist people to either begin or move ahead in the behavior change process. In addition, these sessions can help to promote on-going discussions with the community and increase positive interactions with providers.

Determining Health Information Topics

Deciding what topic or type of information to use as the focus of an information session can be determined in a variety of ways and from a variety of sources.

1. In response to current campaign on a specific identified health issue so as to increase the utilization of services at the health facility e.g. Post Abortion Care (PAC) or increasing access to EOC for safe motherhood.
2. A health problem being seen at the health facility with unusual frequency recently (e.g. outbreak of measles, increase of malaria during the rainy season or diarrhea during water shortage).
3. Trends noted in service data (e.g. decrease in antenatal visits, increase in maternal mortality).
4. Issues or concerns identified during meetings/talks with community leaders; e.g. cost of drugs or stock-out of essential drugs.
5. Issues generated out of initial community group sessions.
6. Important new or updated information, especially on a topic of already established interest or need.
7. Recent rumors.
8. Issue(s) that arise during a spontaneous social situation. E.g. a child with vomiting and diarrhea during a naming ceremony.

Brainstorming

- Display FC with steps for planning health session
- Ask volunteers to read and explain what they understand by each step

TRAINER'S NOTES

Planning Health Information Sessions

To be effective, there are steps that should be taken to initiate, plan, prepare, and conduct a “Planned” community health information session. Selected steps will be discussed in greater depth in subsequent sections.

1. **Identify who is the intended audience.** Keep in mind that there will be a *primary audience*. These are the participants who the information is especially intended for. For Safe motherhood Campaign, this is for women of reproductive age, their spouses and relations. In addition, there may be a *secondary audience*. These may be people who have some related interest in the topic, those who may simply accompany a member of the primary audience, and those who attend a session in order to seize the opportunity to raise other issues and concerns. Members of the secondary audience can be an important element in the session, as they may influence the discussion, as well as the decisions and actions of the primary audience. They are family members, community, religious and traditional leaders
2. **Determine ways in which to access or reach the intended audience.**
 - a. Identify leaders or key representatives of groups (e.g. leaders of women/men/youth groups, local government leaders and representatives, church leaders, heads of local work places)
 - b. Seek places where people tend to normally congregate (e.g. religious houses, market places, work places, recreational areas, schools and mechanic village)

Initial contact: The provider should introduce himself/herself and his/her role as a provider of health services, explain the purpose of wanting to meet with the group, discuss possible health issues and information that might be of interest to the group, make a tentative plan for when and where the session will occur, and seek assistance in mobilizing the intended audience. It is often helpful during this initial contact, to also share additional information about some of the provider's other roles in the community that may be related to the group's interests (e.g. a father/mother with children, a member of the same social club, and lives in the same local government area).

Follow-up contact: Finalize the date, venue and topic. Make arrangements for any special needs for the presentation (e.g. equipment, electricity, seating arrangements); try to determine approximate number of people who are likely to attend.

3. Prepare for the session

- a. Develop objectives for the session. What is the problem to be solved or improved in the session? What is intended that the participants will have learned or will do as a result of the session?
- b. Review information on the topic so that it is familiar and up to date.
- c. Organize the information to be presented in logical sequence; prepare some brief prompting notes.
- d. Decide on the approach (es) that will be used to help the audience learn and participate in the session.
- e. Select appropriate visual aids.
- f. Test any equipment that is to be used.

4. Conduct the session

- a. Be punctual. It is discourteous and disrespectful to be late.
- b. Greet and welcome participants warmly; create a rapport with the audience or use a relevant proverb or a joke to set a climate.
- c. Introduce self and anyone else who may be assisting
- d. Acknowledge the presence of leaders and influential people
- e. Introduce the topic in a stimulating way.
- f. Utilize prepared approach (es) for presenting the information.
- g. Encourage the audience to participate and ask questions
- h. Use visual aids to support the topic
- i. Summarize key points
- j. Provide information where participants can obtain more information or services
- k. Thank audience for coming and for their participation
- l. Offer to meet with the group again and ask what they would be interested in meeting about
- m. Give participants reading material to take away with them if literate and pictorial if cannot read or write.

5. Evaluate the session

- a. Observe the audience's interest and amount of participation
- b. Ask a few questions from the content to assess whether the information was learned and understood

- c. Ask whether the audience felt the session was helpful and how they might use what they learned.
- d. Ask if they have questions
- e. Try to determine the number of clients who come for services at the health facility as a result of the talk. This might be accomplished by having the receptionist ask each client for a period of time (ex. 2 weeks following the community session) whether they attended the session and whether it helped them to decide to come to the health facility for services.

2. CREATING AN INTERACTIVE ENVIRONMENT

Discussion

- Display and lead discussion on creating an interactive environment
- Display and lead discussion on approaches and techniques for presenting information in planned community health sessions
- Discuss on appropriateness of each method considering the communities involved
- Display the flip chart and go through instructions for use and information contained on each page
- Make clarifications where necessary
- Role play use of the flip chart taking note of cues for using the visual material correctly
- Consider providing spontaneous community health information
- Trainees to mention differences in approach
- Display FC and fill in any gaps
- Summarize by examining differences between conducting community and health facility group information sessions

TRAINER'S NOTES

Creating an Interactive Environment

Creating an interactive environment for community sessions is very similar to creating the “Welcoming environment” at the health facility. In an interactive environment the participants have the greatest opportunity to learn. It encourages interaction between the provider and participants and between the participants themselves. Ways to help create an interactive environment include:

1. The provider being friendly and approachable. He/she might demonstrate this by welcoming participants, smiling, using relaxed body language, mingling with the audience, etc.
2. Encouraging the audience to participate in discussions, ask questions, and share information and experiences with the group.
3. Use words that make participants feel important, valued and respected.
4. Arrange the session area so that it is pleasant and inviting.
5. Provide comfortable seating for each participant, (if at all possible)
6. Arrange seating so that everyone can see and hear, if at all possible.
7. Check to make sure the session area is clean.

8. Provide educational materials, such as putting up posters (if it is permissible) and providing pamphlets for participants to take home. Take advantage of every opportunity to provide important health information to participants.

Approaches and Techniques for Presenting Information in Planned Community Health Sessions

Using good interpersonal communication skills in the group setting is just as important as it is in the counseling session. These skills include using open ended questions and tactful probing questions, re-stating and paraphrasing to clarify that the provider understood what was said, reflecting feelings and observing body language, and active listening. Using these skills assists the provider to assess what the participants already know or feel about the topic, how well they understand the information being presented, and identify areas that need to be clarified or corrected.

Some points to keep in mind when presenting information:

1. Avoid information overload. **Remember KISS- Keep it Short and Simple/Sensible.** It is a common error to want to impart so much information that the participants become confused. There are limits to the amount of information people can understand and retain.
2. If possible, find out in advance what the audience may already know.
3. Select just a few main points and discussion questions to present.
4. Keep information clear and simple.
5. Use words everyone understands.
6. “A picture is worth a thousand words”; use visual aids whenever possible.
7. Repeat important points and summarize them again at the end of the session.
8. Try to make the information relevant to the participants’ lives, interests and expressed needs.
9. Take plenty of time to explain an important point.
10. Watch for signs of confusion or boredom and provide an appropriate intervention

There are several approaches that can be used to present information in community group settings. Often using a combination of approaches can make the session more interesting and increase participation.

1. Lecture

In general, lectures tend to result in too much information being presented and too little opportunity for group participation. The person who learns the most from a lecture is usually the one who prepared and delivered it. Giving a very brief presentation of carefully selected points of information can be useful to help all the participants have a common base of knowledge.

2. Group discussion

Group discussion is an active learning process that involves the use of questions and answers. It allows for the sharing of ideas, feelings, and experiences. It gives the

presenter immediate feedback on the group's understanding and information and clarifications can be made immediately.

3. Role play

Role-play is a training approach in which participants act out problems or situations. It can be a powerful and exciting way to help participants become aware of the feelings of others and see a situation through the eyes of others. It is also a good way of trying to resolve a problem. It generates discussion and active participation.

4. Problem situations (Case studies)

Presenting a problem situation gives participants the opportunity to apply new knowledge to a specific situation. It stimulates discussion and participation. The problem situation should be realistic and relate to the life situation of the participants. The statement of the problem should be brief and simply worded.

5. Videos

Showing a video followed by discussion is an effective teaching approach. It requires special equipment, but can be a very good way of holding the attention of the group.

6. Drama

Presenting a short drama skit followed by discussion is another effective teaching approach. This is a very good way to enact certain positive behaviors or situations, ex. what happens (or should happen) at a selected type of clinic visit (e.g. an antenatal visit). Participants learn what they should expect from the visit and often freely offer feedback about what their experience has been.

7. Story telling

When using storytelling, participants are presented with a picture (**Refer Better Health Kit and Campaign Materials**) and asked to say what they see in the picture and tell what they think is happening.

8. Song, dance and puppet shows

These approaches can also be used effectively in community sessions. They may help to bridge language barriers and incorporate very traditional methods of passing information. They require special expertise to utilize effectively.

9. Demonstration

Learning a new skill is most effective through use of demonstration and return demonstration. In group sessions, this can be done utilizing models and asking for volunteers to return the demonstration. Learning through seeing and doing is more effective than just explaining verbally. Allowing for return demonstration helps to build up on the skills of learner. Helps to reinforce positive behavior change through repetition and active listening

10. Audio -cassettes or radio programs.

Principles of Adult Learning

In contrast to children, adults have a large volume of previous experiences and knowledge. Based on these experiences and knowledge, they already have well developed ideas about how the world functions and the way people and events relate to one another. When conducting community health sessions, it is helpful to understand some of the principles that make adult learning situations more effective.

1. Adults learn the most when they can participate actively in the learning process, such as in role-play and from discussion of real life situations. If their participation is limited to the role of passive recipients of information, the learning will not be as effective.
2. Adults need to understand why or how the information is important to their lives and how it can provide something beneficial when put into practice.
3. Regardless of his or her level of formal education, each person brings knowledge and experiences to the learning situation.
4. Adults learn best when they can apply the new information immediately.
5. Adults enjoy and respond to humor and some entertainment in the learning process.
6. Adults respond to learning in the safety of group situations.
7. Adults are much more motivated by praise than by criticism.
8. Adults have less time for learning, because of many other responsibilities.
9. The attention span decreases with age. Therefore more frequent, short sessions are most effective.

In conducting community health sessions, the provider needs to be flexible and use good recovery skills when things don't go quite as expected.

Differences between Conducting Community and Health Facility Group Information Sessions

Many of the same steps and principles apply to conducting a planned health information session for a group, whether it occurs in the community or at the health facility. At the same time, though, there are some differences that the provider should consider and be aware of. Some of these differences include:

1. When going out to the community to conduct a session, it is very important to prepare carefully and to take everything you will need. At the health facility it is relatively easy to pick something that may have been forgotten (e.g. a specific visual aid).
2. Motivation for the participants to attend the sessions may be quite different. Clients who are already at the clinic and who are included in a health talk, may be highly motivated because they already are seeking health services and information; on the other hand, they may be a captive audience and sitting through a talk because there is little choice while waiting for the care they came for. In the community, people who attend a health talk are usually highly motivated because they had to make a special effort to come for the session.
3. Unlike clinic clients who are already mobilized, it may be much harder to mobilize community members for a health session.

4. The provider has much more control over the health facility setting (e.g. scheduling, interruptions, etc) than he/she may have in the community setting.
5. Training conditions may be quite different. In the clinic, the waiting room is usually used and is already set up. In the community, the venues may be less conducive to holding a group health session. The provider is wise to familiarize himself/herself with the community venue in advance.
6. The size of the group can vary considerably. The actual number of participants who attend the community session could be a surprise.
7. At the health facility the composition of the group is usually fairly homogenous. In the community, although there is an intended primary audience, the composition of the group could be very mixed.
8. At the health facility, the topic for a health talk is usually quite focused and tends to remain that way. In the community, the topic can easily lead to many other issues and concerns. The latter is often the result of a mixed audience, but is also one of the reasons providers are encouraged to go out to the community. Giving health information talks provides the community and the provider the opportunity to also interact on other topics and issues.
9. Health talks at the health facility usually proceed on schedule and clients quickly come to know when they will occur. In the community, a session may have been scheduled, but can suddenly be pre-empted by another community event such as a funeral of an influential person, a local sports event, etc.

Spontaneous Health Information Sessions

Health care providers frequently have opportunities to provide health information when participating in social events in the community. These situations can present a challenge in knowing how to handle, but the opportunity and responsibility to contribute, correct, or clarify health information should not be lost. Although the provider would not normally go to a social event prepared to conduct a planned health information session, it is important to consider how he/she would respond spontaneously in such a situation.

Planning

The best way to plan for responding to and taking action in a spontaneous situation is to visualize possible situations and imagine how he/she would handle them.

Preparation

Preparing for the spontaneous situation consists mainly of developing a “mental set” or frame of mind. In other words, the provider needs to be alert to opportunities to intervene, and be willing to take action. The provider may feel less secure without having had the opportunity to review and refresh their knowledge about a topic, as they would have done before conducting a planned health information session. To help overcome this concern, it is important to remember that knowledge is relative. The provider works with health information and issues every day. Therefore in a social situation, it is reasonable to assume that the provider knows more about the health topic

than the other participants in the discussion. As in any other situation, if the provider does not know an answer, he/she should acknowledge that they do not know but offer to get the information.

Suggestions for handling the situation

1. If it is a group of people who are unknown to the provider, he/she should introduce himself/herself and his/her role as a health provider. If it is a known group, the entry is much easier.
2. Enter the conversation in a friendly, non-threatening way. Ex. "I heard you talking about Treating Abortion" and it sounds like an interesting discussion. Do you mind if I join in?"
3. Re-state what was heard to make sure that it was heard and understood correctly. This might also be a good opportunity to reflect feelings. For example, "It seems that you are worried about how the number of women who die as a result of pregnancy and childbirth"
4. Try to assess what the participants already know about the topic (possibly a rumor) that is being discussed. This is a good opportunity to use open-ended questions. Ex. "What makes you think that?"
5. Offer appropriate information. Keep the information brief, clear, and simple. Use terms that are easy to understand.
6. Ask a question to re-stimulate discussion. This will help to determine whether the information provided was helpful and understood.
7. Offer to continue the discussion at some other time. Provide information about services and information (including IEC materials) available at the health facility. In these situations, be calm and friendly. Respect the social event and the people attending it. Try not to monopolize the conversation or pre-empt the event. Use good judgment as to when to conclude your participation in the discussion. When satisfied that the health topic has been adequately handled, turn the conversation back to a more social nature once again.

Opportunities to provide health information can also present themselves through observations, not just from verbal discussions in the community. As the health provider moves around through the community, he/she should be aware of situations and behavior that he/she observes that would benefit from spontaneous intervention and provision of health information.

In all community situations, the provider is an "Ambassador for Health". This means utilizing every opportunity to share one's knowledge and to demonstrate the qualities of a "caring" provider, who is also a "caring" member of the community.

4. CONCLUSION

- Ask participants what they feel about community interaction

- Ask participants to reflect on what they have learnt that will influence changes to improve services in general.

Application

- Ask participants in what situation they can use acquired knowledge
- Ask for clarifications to ensure applications relate to learning's
- In your situation, how easy will it be to interact with the community?
- What resources (besides money) will help you to do this?

Evaluation

- Why is working with the community an important aspect of a health system?
- What can we do to improve provider-community interaction?

Summary

- Review session objectives checking to what extent these have been met.

Day 5 - SESSION 18

TOPIC: *Monitoring and Evaluation of IPC/C Skills*

TIME: Two hours

OVERALL GOAL: Participants will apply the IPC/C skills learned in an integrated fashion before they return to work.

OBJECTIVES: By the end of this session, participants will have:

1. Listed benefits of using self-assessment.
2. Described the three A's of self-assessment.
3. Discussed importance of effective feedback.
4. Described the four elements of a peer review meeting.
5. Listed benefits of peer review.
6. Practiced with both self-assessment and peer review methods

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction and Review	15 min	Group discussion	
2. Effective Feedback	20 min	Group discussion Small Group	Power Point Flip chart, Markers
3. Integrated Skills Practice	60 min	Small Group Practice	Flip chart, Markers
4. Use of Observation Checklist	15 min	Small Group Practice	Observation checklist
5. Summary and conclusions	10 min	Large Group	

OVERVIEW: This is a key session to pull together all the skills learned during the workshop. Emphasis should be on working out any last questions or clarifying any last skills before participants return to their work site.

1. INTRODUCTION

During this session, participants not only integrate cognitive information learned during the workshop, but also integrate the discrete skills taught during specific previous sessions, increase awareness of their counseling strengths and weaknesses and become more skillful observers of the counseling process. This session aims to pull together everything shared thus far.

TRAINER'S NOTES

A crucial component of the counseling training workshop is supervised practice. Even though previous sessions are designed to be participatory and experiential, participants learning to counsel effectively need the opportunity to integrate all the counseling skills by practicing and receiving feedback on their performance. The workshop design allows for the participants to observe others counseling and to be observed themselves.

Discussion and Review

Ask participants to describe the key components of effective counseling (review of GATHER). [**Show Slide**].

Next, ask participants to describe the key principles in using IEC materials during counseling situations.

Ask for any questions and clarify if necessary.

Ask the group to consider what they learned from the previous sessions on transferring learning from training to work by responding to the following questions:

- What will you do to retain your new knowledge and skills on interpersonal communication and counseling?
- What are you going to do to continue to learn about IPC/C and to improve your skills?
[**Trainer to use VIPP cards, 2 cards per participant to write their responses**].

Tell the group that together we will learn how to use special self-assessment tools that can help them retain their new skills and to continue learning. These tools use both **intrapersonal communication** (when we talk to ourselves) and **interpersonal communication** to reinforce learning and skills.

2. BENEFITS AND HOW-TO'S OF SELF-ASSESSMENT

Trainer's Notes

In family planning programs where human and material resources for continuous training and follow-up supervision visits are limited, self-assessment may be an alternative way to maintain and improve provider communication skills. The idea of self-assessment as a low cost, sustainable, and

self-empowering intervention is attractive, yet it has rarely been put into practice. We are going to learn how to use self-assessment and peer review to maintain and improve provider skills learned during this IPC/C workshop.

Activity

A. Introduce the topic of self-assessment via a role play. Ask the participants to observe carefully what is occurring. Two trainers play the role of two providers who have just completed their counseling sessions and are talking together.

Role Play

Scene: Two counselors are talking at the end of the day. They have both seen a number of clients. Counselor A is holding the self-assessment form in her hand, having completed the form. Please adjust the dialogue to make it natural for you.

Counselor A: You will model three skills (the three “A’s”):

1. **Awareness:**

Providers should be aware of their own communication behaviors and the client’s communication behaviors.

You will be able to talk about your behavior -- what you did that worked and what you would like to do better.

2. **Analysis:**

Providers should analyze their communication behavior and interaction with clients using self-assessment forms -- or some other criteria they set for themselves.

You will be systematic and logical in observing your behavior, thinking about your strengths and weaknesses, and referring to self-assessment forms.

3. **Action:**

Providers should plan and take specific actions to improve their IPC/C skills. They should monitor their achievements and replan as necessary, setting further behavioral objectives. Thus providers can improve their skills continuously using self-assessment tools.

You will have specific ideas about what behaviors you want to improve and how you are going to work on them.

Counselor B: You will model a **lack of** awareness, analysis, and any planned actions to improve your communication skills.

Sample Script

Counselor B: Hello, A, I’m so happy our day is done and we can go home. I’m very tired. I saw ten clients with all kinds of problems.

Counselor A: B, I'm also really tired but I'm feeling pretty good about myself. I noticed that I'm asking more open-ended questions. When I ask more open-ended questions, I get more information from clients. For example, I never thought a client would tell me that she has a terrible memory and would have a hard time remembering to take the pill every day. But when I asked her if there was anything that might cause her to miss taking the pill, she said, "My memory!"

Counselor B: I never ask those kinds of questions. At least I don't think I do – I really don't know what I do.

Counselor A: I've become a better counselor since I became more aware of my performance. I'm in total control now. I analyze and decide what behaviors I need to do better. I also pat myself on the back when I do well. I'm getting more appreciation from my clients now and feel like I'm really helping people.

Counselor B: I don't have time to try to improve myself, and who cares if I'm a good counselor or not?

Counselor A: Aren't you worth a little bit of time every week to learn to do something better, to feel good about yourself?

Process the role play by asking these questions:

- What did Provider A understand about her performance as a counselor?
- What did Provider B understand about her performance as a counselor?
- What was the difference between the two providers?

Trainer: Reinforce comments that relate to the 3 A's of self-assessment (Awareness, Analysis, and Action)

B. Ask the participants:

- How do you know that you are doing a good job?
- What is the first step you can take? (Reinforce comments that relate to intrapersonal communication, that is, what we say to ourselves.)

Tell participants that these issues relate to three important elements of self assessment. Show them **Slide**. Briefly explain the 3 A's of self assessment.

C. Distribute **Self-Assessment Forms**. Review the tool with the group:

1. Reinforce how it focuses on the GATHER skills taught during the IPC/C training (**Show Slide**)

2. Each self-assessment form has 3 parts:

- Part A. Checklist of provider skills and behaviors and

- Part B. Reflection (questions to ask ourselves)
- Part C. Planning for behavior change (current behavior of concern, goals, and monitoring results).

3. Notice the response scales in Part A:

a. For provider: Never, Rarely, Sometimes, Usually, and Always

D. Invite the group to consider a recent practice session and to complete a self assessment form based on that experience.

E. Divide participants into groups of two. Ask them to share their self assessment forms with their partners and then to demonstrate the behavior they want to change as part of a role play with their partner. In the role play, the “client” is free to choose the topic to be discussed. (Give the groups 30 minutes for this activity)

F. Brainstorm with the group about the benefits and obstacles to completing the forms at their jobs.

1. Why would a provider not do it?

- Some persons have difficulty admitting their own weakness
- No time
- Fear that somehow they will be judged
- Assessing oneself may make one feel awkward or uneasy
- Other reasons?

2. Discuss ways to overcome these obstacles.

3. Why would a provider (you) want to do this? How could it benefit you?

- Desire to do the best job possible
- Interest in providing quality services.
- Concern with client’s well being.
- Want a reputation in the community as a good provider
- Like helping people.
- Like being appreciated by the client for doing a good job.
- Other reasons?

TRAINER’S NOTES

The three “A’s” of self-assessment are:

1. Awareness: Providers should be aware of their own communication behaviors as well as the client’s communication.

2. Analysis: Providers should analyze their communication behavior and interaction with clients using the self-assessment forms -- or some other criteria they set for themselves.

3. Action: Providers should plan and take specific actions to improve their IPC/C skills. They should monitor their achievements and replan, setting further behavioral objectives. Thus, providers can improve their skills continuously using self-assessment.

Consider the observer forms that we have been using throughout the training...

How and when to use	The provider fills out one self-assessment form per week, focusing on a different skill area each week for eight weeks. If desired, the provider can then repeat the series. It is important that the provider fills out the form immediately after finishing the counseling session, while it remains fresh in her/his memory. Thus it is important that the provider have some free time right after the session designated for self-assessment.
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3. FEEDBACK VIA PEER REVIEW

A. Ask participants to recall the discussion on feedback from session 15.

Show Slide

FEEDBACK

Is the communication to a person or to a group of people about the effect of the behavior of the person, or group on another person.

Another definition is:

Feedback is information/a message which is given to someone about the result and quality of work. Good feedback will give encouragement to that person to maintain what has been considered good and at the same time, to use the suggestions to increase knowledge or their skills in the future.

As we all know, giving feedback is not easy. But effective feedback allows us to grow and to learn from experiences. The goal of positive and constructive feedback is to bring about changes in our attitude and behavior.

Continue by asking the group:

- What kind of meetings do you have at your job?
- Do you ever have meetings where the topic is people's performance on the job? If **yes**, describe the meeting? Who leads it? What happens at the meeting?
- Do you ever have meetings of just the providers?

B. Trainer introduces tool for peer-review meetings.

Present the four elements of a peer-group meeting, using **Slide**: listening, giving feedback, sharing, and receiving feedback

Ask the group what they've learned about each of these four elements from their IPC/C training, especially during the feedback process about their counseling practices.

Emphasize that it is important to listen attentively when other participants in a group meeting are expressing their opinions or experiences. (Here the role of discussion leader is important. He/she should lead the discussion so every member of the group can participate actively and so that the process of discussion can meet its goal.)

Distribute the **Peer Review Meeting Guide** and describe its three sections:

- a. Opening
- b. Self-assessment form review
- c. Personal Planning (sharing ideas about further behavior change)

C. Trainer invites four volunteers to hold a meeting, while the others observe. The trainer also participates as a member of the meeting to ensure that they model a good peer review session. The trainer (or co-trainer, if possible) facilitates discussion of the meeting afterwards, asking for the group's opinions of what just took place.

D. Brainstorm with the group about these questions:

- Why would providers not want to participate in peer review meetings? (What obstacles would providers face?)
- How can providers overcome these obstacles?
- What is the value of peer review meetings? How do they benefit providers?

Value of peer-group review meetings:

1. Creates an organizational climate that supports IPC/C skills improvement
2. Gives providers an opportunity to give and take some lessons learned in applying the skills learned during the training.
3. Provides an opportunity to integrate IPC/C skills.
4. Facilitates structure to keep monitoring one's progress.

E. Divide participants into groups of 5, and ask each group to practice holding a peer review meeting.

TRAINER'S NOTES

Once a month (or more!), all the providers who offer reproductive health services in each clinic will meet to discuss lessons learned and plans to improve specific IPC/C behaviors based on

their self-assessments (one per week, so about 4 per person). Each meeting will last 30 - 60 minutes. One person will be elected by the participants to keep the process on task and to facilitate the discussion. While the peer review guide outlines minimum requirements for discussing each skill area, it is only a guide and should not limit the content of the discussion.

4. CONCLUSION

Application

Ask volunteers to describe one strength they now have for giving effective counseling and one area (skill) they would like to strengthen. Ask them to identify what would keep them from implementing this skill in their work situation.

Evaluation

Ask participants to mention the Three “A’s” of Self-Assessment
Ask volunteer to tell the importance of Peer Review meetings

Summary

Review the session objectives checking to what extent it has been met
Summarize the major points of the session.

GATHER SELF ASSESSMENT FORM

NAME: _____ DATE: _____	SCALE: Always = 5 Usually = 4 Sometimes = 3 Rarely = 2 Never = 1
AREAS OF COMPETENCE	SELF-SCORE
G is for GREET (This includes establishing rapport, and observing the client throughout the session with them)	
I greet the client respectfully and warmly	
I ensure the counseling environment is private and comfortable	
I use eye contact in a natural and culturally appropriate	
My facial expression communicates caring and interest	
My gestures communicate caring, interest and acceptance	
My body posture is natural, relaxed and attentive	
I assure confidentiality	
A is for Ask	
I ask reason for visit	
I can follow or "track" what the client's saying or the client's topic	
I do not interrupt	
I ask one question at a time	
I refrain from leading questions or cross-examining	

<p>I use counseling skills effectively (try to score each of these):</p> <ul style="list-style-type: none"> • Paraphrasing • Summarizing • Reflecting feelings • Open-ended questions when appropriate • Closed-ended questions when appropriate • Use of Encouragers (praise, reassurance, encouragement) to foster dialogue 	
I use appropriate non-word noises that encourage client to talk	
I pay attention to the client's nonverbal cues (glances, gestures, bodily reactions, voice tones, pauses) and make adjustment to my style based on them.	
I pay attention to the client's verbal cues (content, voice tones, pace)	
My rate of speech communicates empathy, caring, interest, involvement	
I am comfortable with managing silence	
T is for Tell	
I am not judgmental	
I respect the client's opinion	
I respond directly and completely to client's questions and statements	
If the client brought up a rumor, I respond with accurate information.	
I legitimize the client's concerns and anxieties	
I explain technical concepts in words the client can easily understand, and relate them to the client's personal situation	
I invited the client to tell me whenever he or she did not understand something.	
I checked to be sure that the client understood and remembered technical information.	
I feel prepared technically about issues relevant to the client such as :	

a. ----- Sexuality (post-abortion care, safe motherhood)	
b. ----- If young (physical changes during youth)	
c. ----- Relationships (family, peers, work/school)	
d. ----- STDs/HIV/AIDS	
I am comfortable talking about things related to sex	
I provide information that is directly tailored to the client and his/her circumstances and needs. If a client needs more information than I can offer, I know who to refer them to, or other resources to find the information.	
I am comfortable using IEC materials appropriately	
H is for Help	
I invite the client to ask questions	
I help client to identify problems and solutions	
I refrain from offering sympathy or solutions prematurely	
I let the client do most of the talking	
I keep the client focused for a discussion relevant to their specific situation	
I identify accurately and communicate understanding of client's feelings	
I use my counseling micro-skills to <u>carefully</u> clarify any areas where the client may be vague or contradictory in their answers.	
I assist clients to develop options	
I assist clients to examine consequences of each option	
I let the client make the decision	
E is for Explain	
I am able to present a concise, accurate and timely summary of themes presented by the client	
I confirm any decisions or choices by client; checking commitment	

I guide the client in thinking through his or her choice and adopting related behavior change	
I demonstrate knowledge of support and referral resources	
R is for Return	
I encourage the client to return for follow up as necessary, if he or she has any questions, or if he or she experiences any problems.	
I invite the client to bring or send others	
I thank the client for coming	
NOTES:	

Part B. Reflection

. If the client had spoken more openly, how would that have helped you do a better job counseling?

. What could you have done to encourage the client to speak more openly and at greater length?

Part C. Planning for Behavior Change

List two specific behaviors that you will work to change this week to improve your ability to encourage clients to participate in counseling sessions. You might want to do something more often, stop doing something, or try a new way of talking to your clients.

PERSONAL PLANNING WORKSHEET FOR TRANSFER OF LEARNING				
My Personal Learning Goals (areas where I'd like to improve my counseling, knowledge, skills and attitudes) Be specific, concrete, and realistic.	By when will I take these actions ?	Resources or Opportunities available to me	Person(s) who can give me feedback in this area	RESULTS

GATHER PEER REVIEW DISCUSSION GUIDE

G is for GREET

Part A. Opening

Discuss why it is important to form a good rapport with clients. What are you able to convey to them right away? What techniques have you used to establish rapport with your clients? How can observing them throughout your session help you help them more effectively? How do clients feel when you express positive feelings towards them? How does this affect clients' attitudes, decisions, and actions?

Part B. Reviewing Self-Assessment Forms

Go around the group and have each provider answer the following questions:

- Which two behaviours did you try to change this week and why?
- How much success did you have in changing your behaviour? Was it difficult?
- How did clients respond to your efforts? How did *you* feel?

Part C. Sharing Ideas about Further Behaviour Change

Have the group draw on their experience to discuss the following issues:

- How do clients react when you express positive emotions? How does it change what they say and do during the session?
- Is it ever okay to express negative emotions (such as criticism or scolding) towards clients? If so, on what occasions? How do negative comments make clients feel?
- What are some ways that you can separate your personal opinions from your professional responsibilities as a health care provider?

Decide, as a group, on the five best ways (either verbal or nonverbal) to express positive emotions to clients.

Try to incorporate these into your counseling skills.

PEER REVIEW DISCUSSION GUIDE

A is for ASK

Part A. Opening

Discuss why it is important to listen carefully to clients. What kinds of things do you miss when you are not concentrating on the client's words? What message are you sending to the client when you seem distracted or disinterested?

Part B. Reviewing Self-Assessment Forms

Go around the group and have each provider answer the following questions:

- Which two behaviours did you try to change this week and why?
- How much success did you have in changing your behaviour? Was it difficult?
- How did clients respond to your efforts? How did *you* feel?

Part C. Sharing Ideas about Further Behaviour Change

Have the group draw on their experience to discuss the following issues:

- How do clients feel when they sense that you are not interested in their problems and not listening to them? How does it change what they say and do during the session?
- How can you maintain your concentration and listen to each client attentively throughout a long day with many clients?

Decide, as a group, on the five best ways (either verbal or nonverbal) to signal clients that you are listening attentively.

Try to incorporate these into your counseling skills.

PEER REVIEW DISCUSSION GUIDE

T is for TELL, Part I

Part A. Opening

Discuss why it is important to respond to clients' questions and concerns. What message does it send when you ignore or dismiss a client's question or concern? How does it change what they say and do during the session?

Part B. Reviewing Self-Assessment Forms

Go around the group and have each provider answer the following questions:

- Which two behaviours did you try to change this week and why?
- How much success did you have in changing your behaviour? Was it difficult?
- How did clients respond to your efforts? How did *you* feel?

Part C. Sharing Ideas about Further Behaviour Change

Have the group draw on their experience to discuss the following issues:

- How can you make sure that you've responded fully and that the client is satisfied with your explanations?
- How can you show your respect for the client and their concerns?

Decide, as a group, on the five best ways (either verbal or nonverbal) to show clients that you appreciate their concerns.

Try to incorporate these into your counseling skills.

PEER REVIEW DISCUSSION GUIDE

T is for Tell, Part II

Part A. Opening

Discuss what messages your nonverbal behaviours send to clients. How does it affect what they say and do?

Discuss what messages the client receives from the way in which you present information, i.e., from your choice of words, the length of your explanations, and whether you relate that information to the client's personal situation.

Part B. Reviewing Self-Assessment Forms

Go around the group and have each provider answer the following questions:

- Which two behaviours did you try to change this week and why?
- How much success did you have in changing your behaviour? Was it difficult?
- How did clients respond to your efforts? How did *you* feel?

Part C. Sharing Ideas about Further Behaviour Change

Have the group draw on their experience to discuss the following issues:

- Which kinds of nonverbal behaviour are most important: eye contact, facial expressions, gestures, tone of voice, or seating arrangements? How can you become more aware of your nonverbal behaviours?
- How can you make sure that a client really understands the information you have explained? When you are not sure about some piece of technical information that is important for the consultation, what should you do?

Decide, as a group, on the five nonverbal behaviours that are most helpful in communicating with clients.

Try to incorporate these into your repertoire.

Decide, as a group, on the five best ways (either verbal or nonverbal) to explain information to clients.

Try to incorporate these into your counseling skills.

PEER REVIEW DISCUSSION GUIDE

H is for HELP

Part A. Opening

Discuss why it is important to get complete information from the client. How much and what kinds of information do you think you need from clients to do a good job of counseling them?

Part B. Reviewing Self-Assessment Forms

Go around the group and have each provider answer the following questions:

- Which two behaviours did you try to change this week and why?
- How successful were you in changing your behaviours? Was it difficult?
- How did clients respond to your efforts? How did *you* feel?

Part C. Sharing Ideas about Further Behaviour Change

Have the group draw on their experience to discuss the following issues:

- What kinds of questions seem to elicit the most information from clients?
- When should you follow up a client's remark with probing questions?
- How else can you prompt clients to disclose information, besides asking questions?

Decide, as a group, on the five best ways (either verbal or nonverbal) to elicit information from clients.

Try to incorporate these into your counseling skills.

PEER REVIEW DISCUSSION GUIDE

E is for EXPLAIN

Part A. Opening

Discuss why it is important to check that clients understand the consequences of their decision and have a good reason for choosing that particular course of action. What may happen if clients make hasty and ill-thought decisions? How can you familiarize yourself with referral options that may support a client in his or her health decisions?

Part B. Reviewing Self-Assessment Forms

Go around the group and have each provider answer the following questions:

- Which two behaviours did you try to change this week and why?
- How much success did you have in changing your behaviour? Was it difficult?
- How did clients respond to your efforts? How did *you* feel?

Part C. Sharing Ideas about Further Behaviour Change

Have the group draw on their experience to discuss the following issues:

- How many options should you give clients? How much time should you spend discussing alternatives when the client comes in knowing what she wants?
- How involved should you get in a client's decision? Is it ever okay to make the decision for the client?

Decide, as a group, on the five best ways (either verbal or nonverbal) to help clients make a wise decision.

Try to incorporate these into your counseling skills.

PEER REVIEW DISCUSSION GUIDE

R is for RETURN

Part A. Opening

Discuss why it is important for clients to actively participate in counseling sessions. What kinds of things do you miss when clients don't speak fully or freely? How does this affect your ability to advise clients? How does it affect the likelihood that they will return if they have problems, or that they will bring friends or family to your clinic?

Part B. Reviewing Self-Assessment Forms

Go around the group and have each provider answer the following questions:

- Which two behaviours did you try to change this week and why?
- How much success did you have in changing your behaviour? Was it difficult?
- How did clients respond to your efforts? How did *you* feel?

Part C. Sharing Ideas about Further Behaviour Change

Have the group draw on their experience to discuss the following issues:

- What kinds of obstacles discourage clients from talking openly? What can you do to help overcome these barriers?
- When clients are shy and don't want to talk much, how much pressure should you put on them to participate?
- Considering all of the pieces of GATHER, what do you find is most important in encouraging clients to come back to your clinic?

Decide, as a group, on the five best ways (either verbal or nonverbal) to encourage clients to speak more openly and at greater length.

Try to incorporate these into your counseling skills.



Day 5 - SESSION 19

TOPIC: *Workshop Synthesis and Evaluation*

TIME: One hour

OVERALL GOAL: To provide participants an opportunity to ask final questions about the IPC/C workshop content.

OBJECTIVES: By the end of this session, participants will have:

1. Discussed any doubts regarding the content of the IPC/C workshop.
2. Answered the Post Training Evaluation and Workshop Evaluation Questionnaires.
3. Received their certificate of completion of the IPC/C workshop.

OVERVIEW

This session is really to discuss with the participants any doubts concerning the content of the IPC/C workshop, and evaluate both the learning during the workshop and the whole workshop as a whole. After which certificate of completion of the IPC/C workshop will be given to deserving participants.

CONTENT

WORKSHOP SUMMARY

- Ask a volunteer to briefly share key points of the workshop.
- Ask participants to list the skills that were discussed in the workshop.
- Ask how they plan to use the skills in their work.
- Also ask participants if they have any questions that need answering.
- Respond to all questions.
- This is also a time for participants to contribute any final overall feedback on Interpersonal Communication and Counseling skills workshop.
- What would they like to see added, deleted or improved? You can then incorporate these ideas into future workshops.
- Thank participants for all their contribution during the workshop.

WORKSHOP QUESTIONNAIRES

- Distribute the Post Training Questionnaire
- Have participants respond to the questionnaire

WORKSHOP CLOSING

The workshop closing is the final ceremony where participants receive their certificates of completion, and honored guests say a few words. If no honored guests are available, trainers should say some concluding remarks to bring closure to the workshop.

End of Training Evaluation Form

1 Which sessions/topics did you enjoy the most this week?

.....
.....

2. Which did you enjoy least?

.....
.....

3. What did you learn during this workshop that was of most value to you?

.....
.....

4. How do you think your role as a Health Care Worker will improve after this training?

.....
.....

5. Mention two things you will do differently in your health facility after this training

1.....
2.....